FACE SHEET

FISCAL YEAR/S COVERED BY THE PLAN

_X__FY 2006 ___ FY 2006-2007

STATE NAME: _____ARKANSAS_____

DUNS #: ____119841336_____

I. AGENCY TO RECEIVE GRANT

AGENCY: __Department of Health and Human Services_____

ORGANIZATIONAL UNIT: ___Division of Behavioral Health Services_____

STREET ADDRESS: _____4313 West Markham Street_____

CITY: __Little Rock_____STATE: _ Arkansas____ ZIP: ___72205-4096____

TELEPHONE: ___(501) 686-9164___ FAX: __(501) 686-9182____

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: Patricia Dahlgren TITLE: _ Director, Division of Behavioral Health Services_

AGENCY __Department of Health and Human Services_____

ORGANIZATIONAL UNIT: ___Division of Behavioral Health Services_____

STREET ADDRESS: 4313 West Markham Street_____

CITY: __Little Rock___STATE:___Arkansas____ ZIP: 72205-4096

TELEPHONE: ___(501) 686-9164_____ FAX: __(501) 686-9182_

III. STATE FISCAL YEAR

FROM: __July___ ___2005____ TO: _June 30_____ _____2006____

Month Year Month Year

III. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME: __John Althoff, Ph.D. TITLE:___Assistant Director, Adult Services___

AGENCY: ___Department of Health and Human Services_____

ORGANIZATIONAL UNIT:___Division of Behavioral Health Services_____

STREET ADDRESS:___4313 West Markham Street_____

CITY:___Little Rock_____STATE:___Arkansas_____ ZIP: ___72205-4096___

TELEPHONE: 501-686-9166_ FAX: 501-686-9182 EMAIL: john.althoff@arkansas.gov

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EXECUTIVE SUMMARY

The Division of Behavioral Health Services (DBHS) is Arkansas' Single State Agency for both Mental Health and Substance Abuse Treatment/Prevention services. DBHS discharges its responsibility for the provision of public mental health services by operating the Arkansas State Hospital (ASH) and the Arkansas Health Center skilled nursing facility, by contracting with fifteen local, private non-profit Community Mental Health Centers (CMHC), and by certifying three private non-profit specialty Community Mental Health Clinics. Each CMHC serves a designated geographic area and serves as the single-point-of-entry to the public mental health system for its catchment area. DBHS is part of the Department of Health and Human Services and provides formal leadership for the public mental health system through its participation in the executive functions of state government. It also allies itself with other organizations to advance the cause of public mental health, including the Arkansas Mental Health Planning and Advisory Council (AMHPAC).

Areas of previous state plan focus and related achievements include: data system development, the role of Medicaid in financing mental health services, furthering the integration of mental health and substance abuse treatment, promotion of the greater availability of evidenced based practices (EBP), expansion of access to local acute inpatient care for adults, CASSP Coordinating Council focus on early childhood, and the expansion of school-based mental health services.

New developments and issues affecting the public mental health system include: increased funding for local inpatient care for adults, ongoing developments in Medicaid (in particular, efforts to control costs for children's mental health services), plans to replace the existing state hospital with a new facility, preparation for implementation of the Medicare Part D prescription drug benefit, merger of the Department of Health and the Department of Human Services to form the Department of Health and Human Services, further enhancements in the data system, and recent legislation to provide for enhanced coordination of children's services.

The primary strength of the child and adult comprehensive community-based system of care is the existence of a well established, stable group of public mental health providers- the 15 CMHCs and three Mental Health Clinics. All of the CMHCs provide the basic array of crisis intervention/stabilization, clinical and rehabilitative services. Of course, the breadth of services within the basic array varies among Centers, and with few exceptions evidenced-based practices (EBP) with known fidelity to the practice model are not in place. It is a priority goal of DBHS to promote the initiation and dispersal of EBPs more widely throughout the system of care while maintaining current programs that support the goals of a community-based system of care. With regard to children's EBPs in particular, school-based mental health services have been a priority of DBHS. All CMHC's provide school-based services in their catchment areas with most planning to increase these services in the next year. DBHS and the Department of Education are combining funds for five grants to support the expansion of school-based mental health services and implementation of positive behavioral supports. These grants began in the 2004 fall term.

A strength of Arkansas' public mental health system is that a number of providers have housing programs, some quite extensive. CMHC-controlled housing options are readily available to

SMI/SED individuals that have become homeless or are at-risk of homelessness. Another strength of the public mental health system is that Arkansas' public mental health system was developed and continues to serve its rural population through a widely disbursed system of care. Also a strength in the public mental health system is the Child and Adolescent Service System Program (CASSP), which was established by Arkansas Law. The influence of CASSP has increased in the past few years, with the statewide Coordinating Council having an active membership of more than forty representatives from state agencies, family members, advocacy groups, and private agencies. The CASSP Coordinating Council has had an impact on determining priorities for development in the system of care. As a result, an early childhood mental health initiative was implemented in the past year. This initiative has included specific training made available to the public mental health system to increase the workforce expertise in mental health for young children on a statewide basis. Funding has been established for three demonstration projects in mental health consultation in early childhood.

As noted, DBHS has been involved in ongoing efforts to improve its data system. In monitoring this year's goals, DBHS will, for the first time, be able to determine the unduplicated counts of individuals served and will have available the results of a statewide uniform consumer satisfaction survey based on a random sample of sufficient size to yield valid results. In a number of areas where DBHS had previously set specific numeric targets, it will this year be utilizing its new data capacities to determine baseline performance which will then be used to set targets for future years.

DBHS plans to maintain a comprehensive community-based adult mental health system of care that minimizes inpatient hospital stays, in particular readmission's to ASH, and that delivers services to clients that are viewed by the clients (as measured by consumer satisfaction surveys) as being accessible and effective. DBHS plans to take further steps to move the system of care towards the delivery of care using evidenced-based practices.

Inpatient stays will be minimized by providing timely aftercare to those leaving the Arkansas State Hospital and by providing responsive ongoing case management to those clients most at-risk for hospitalization. In terms of EBP expansion, the first focus will be on increasing the number of individuals who are provided Assertive Community Treatment (ACT).

DBHS will continue to monitor the penetration of the public mental health system in terms of providing services to its target population of adults with serious mental illness and children with serious emotional disturbance. DBHS plans to continue its emphasis on and monitoring of the level of services in rural areas and to the homeless. To further these goals, DBHS will increase the percent of funds under its control directed to community services. As noted, for this year it will be possible to determine the unduplicated numbers of individuals served.

PART B. ADMINISTRATIVE REQUIREMENTS, FISCAL PLANNING, AND SPECIAL GUIDANCE

I. Immediately following are the documents listed below

(1) Block Grant Funding Agreement
(2) Certifications
(3) Disclosure of Lobbying Activities
(4) Assurances
(5) Description of Opportunity for Public Comment on State Pan

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2006

I hereby certify that _____Arkansas_____ agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[1] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2005, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")

21. The term State shall hereafter be understood to include Territories.

(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and

(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and

(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);

(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and

(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

SIGNED COPY ON FILE — 7-26-05

Governor — Date

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub- grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dis-pensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--
  (1) The dangers of drug abuse in the workplace;
  (2) The grantee's policy of maintaining a drug-free workplace;
  (3) Any available drug counseling, rehabil-itation, and employee assistance programs; and
  (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  (1) Abide by the terms of the statement; and
  (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical an mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
SIGNED COPY ON FILE	Governor, State of Arkansas
APPLICANT ORGANIZATION Department of Human Services Division of Behavioral Health Services	DATE SUBMITTED 09-01-05

DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. **Type of Federal Action:**	2. **Status of Federal Action**	3. **Report Type:**
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report _____

4. **Name and Address of Reporting Entity:**	5. **If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:**
☐ Prime ☐ Subawardee Tier _____ , if known: _____ **Congressional Distric**t, *if known:* _____	**Congressional Distric**t, *if known:* _____
6. **Federal Department/Agency:**	7. **Federal Program Name/Description:** **CFDA Numbe**r, *if applicable:* _____
8. **Federal Action Number,** if known:	9. **Award Amount,** if known: $
10. **a. Name and Address of Lobbying Entity** *(if individual, last name, first name, MI):*	**b. Individuals Performing Service**s *(including address if different from No. 10a.) (last name, first name, MI):* No lobbying activities to disclose

11. **Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.**	**Signature:** SIGNED COPY ON FILE **Print Name:** Mike Huckabee **Title:** Governor, State of Arkansas **Telephone No.:** 501-682-2345 **Date:** 7-26-05

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ASSURANCES - NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE
SIGNED COPY ON FILE	Director, Division of Behavioral Health Services
APPLICANT ORGANIZATION	DATE SUBMITTED
Department of Human Services Division of Behavioral Health Services	9-01-05

(5) Description of Opportunity for Public Comment on Plan.

The primary forum for public comment on the State Plan is through the Arkansas Mental Health Planning Advisory Council. Additionally, a notice of the Plan's availability for review and comment is posted on DBHS's web site and in the state's largest circulation daily newspaper.

II. SET ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

Data Reported by:

State FY _____X_____ Federal FY_____

State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2004	Actual FY 2005
$ __2,955,792___	$ __3,683,246_____	$ _3,248,470____

III. MAINTENANCE OF EFFORT REPORT

MOE Reported by:

State FY ____**X**_____ Federal FY_____

State Expenditures for Mental Health Services

Actual FY2003	Actual FY 2004	Actual/Estimate FY 2005
$__57,027,374___	$__61,498,223__	$___64,369,127_____

IV. STATE MENTAL HEALTH PLANNING COUNCIL REQUIREMENTS

(1) Membership Requirements

Membership requirements are stated in Article IV of the Arkansas Mental Health Planning Advisory Council (AMHPAC) By-laws. See document below.

(2) State Mental Health Planning Council Membership List and Composition

See TABLES 1 & 2, following the AMHPAC By-laws..

(3) Planning Council Charge and Role

Planning council charge and role are stated in the AMHPAC By-laws below. See especially Articles II and III.

(4) Planning Council Activities

See AMHPAC Activity Report following TABLE 2, below.

(5) State Mental Health Planning Council Comments and Recommendations

See Letter from AMHPAC following the AMHPAC Activity Report, below.

ARKANSAS MENTAL HEALTH PLANNING ADVISORY COUNCIL BY-LAWS

Article I. Name

Section 1.01

The name of the organization is the "Arkansas Mental Health Planning Advisory Council" (AMHPAC). Collectively, all persons who are appointed as members comprise the Arkansas Mental Health Planning Advisory Council. Each of these persons is also a member of one of five geographic Regions, which correspond with the Department of Human Services' geographical boundaries.

Article II. Duties

Section 2.01

As mandated in Public Law 102-321, cited from Section 1914, "(a) ...the State involved will establish and maintain a State mental health planning council in accordance with the conditions described in this section. (b) ...the duties of the Council are: (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans; (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems; and (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State."

Definition: Throughout these Bylaws, the term "Council" means a State mental health planning council. The "State mental health planning council" for Arkansas is named the "Arkansas Mental Health Planning Advisory Council." "Executive Committee" means the Executive Committee of the Arkansas Mental Health Planning Advisory Council.

Article III. Responsibilities

Section 3.01

The Arkansas Mental Health Planning Advisory Council's responsibilities to improve the service delivery in the public mental health system have been identified as:

- to act on concerns that are paramount commonalities in each region, as identified during a series of mental health forums that target consumers and families;
- to identify and assist in the design of pilot programs for specialized services, including prevention services, within their respective region;
- to present position papers to the Division of Behavioral Health Services ("the Division") regarding recommendations for implementation of such specialized programs and/or services;
- to assist the Division to design a system of care to meet the needs of the consumers by matching resources and choices to maximize the consumers' health and quality of life;
- to build a more comprehensive and appropriate network for future needs;
- to plan and advise on policies, procedures, mandates, and regulations set forth by the Division of Behavioral Health Services / Department of Human Services.
- to advocate for the provision of mental health services to persons of all ages with serious mental illness and other mental health needs, particularly as it relates to managed care and the imminent changes in national mental health systems; and
- to network with local communities (i.e., municipal leagues, chambers of commerce, church groups, volunteer agencies, et al.) to help assure the accessibility of services for clients of the mental health system throughout the state.

Article IV. Membership and General Structure

Section 4.01 Composition

As mandated in Public Law 102-321, cited from Section 1914 © Membership -- "(1) In General … The Council [will] be composed of residents of the State, including representatives of --
(A) the principal State agencies with respect to -- (I) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and (ii) the development of the plan submitted pursuant to the Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
© adults with serious mental illnesses who are receiving (or have received) mental health services;
and (D) the families of such adults or families of children with emotional disturbance."

As mandated by the same Public Law, (a) the ratio indicating parents of children with a serious emotional disturbance to other members of the Council shall be sufficient to provide adequate representation of such children in the deliberations of the Council. At least one member may be a representative from the Child and Adolescent Service Systems Program (CASSP). Each Region shall recruit parents of children with a serious emotional disturbance to provide adequate representation of such children in the deliberation of the Council; and (b) at least 50 per cent of the members of the Council shall be individuals who are not State employees and not providers of mental health services. This 50 per cent requirement will be applied to the Council as a whole, although each Region is encouraged to attempt to maintain a similar balance.

Section 4.02: Appointment of Members

It shall be the responsibility of the Director of the Division of Behavioral Health Services to authorize appointments to the Council. Each Region shall submit nominations of prospective members to the Director, Division of Behavioral Health Services. The Nominating Committee of the Region shall recommend prospective members to the Region, and additional nominations will be accepted from the body during Region meetings. The Region members will vote whether to submit each prospective member's name as the Region's recommendation to the Director, Division of Behavioral Health Services.

Section 4.03: Terms of Membership

Terms of membership in the Arkansas Mental Health Planning Advisory Council shall be for three years. Two consecutive terms are allowed for each member. If the member requests reappointment, their Region votes to whether to recommend their reappointment, the Executive Committee recommends their reappointment to the Director, Division of Behavioral Health Services for approval.

In order to encourage stability as the Council grows and expands, membership by-laws Sec. 4.03 involving terms of membership will be suspended from now through June 30, 2000. Members of record between July 1, 1997 through June 30, 2003 will be allowed to serve until June 30, 2003 with those members of record on June 30, 2000 drawing lots to determine length of terms and beginning rotations. The first third will rotate off July 2002, the second third will rotate off July 1, 2003, and the final third will rotate off July 1, 2004.

After a one-year's absence, a former member of the Council may apply for reappointment.

A member may resign before the end of his or her term by sending written notice to the Chair of their Region. The Chair may ask the member to reconsider, but if the member does not wish to withdraw the resignation, the Chair will immediately notify the State Chair, who will notify the Executive Committee and the Director, Division of Behavioral Health Services of the resignation.

Section 4.04: Voting Powers

Within each respective region, members of that region have power to vote. For meetings of the Council as a whole or of the Executive Committee, each Region has a single vote. Members of each Region must decide by majority vote or by consensus, what instructions to give their representative for casting the Region's vote.

Section 4.05: Membership Meetings

The Arkansas Mental Health Planning Advisory Council membership will meet four times per year, or as needed, for purposes such as: member education, systems planning, development of policies and procedures, and such other purposes as benefit from the participation of the entire group. These meetings are open to the public. Two weeks' written notice will be sent from Division of Behavioral Health Services to all Council members before such a meeting. At these meetings, each Region has a single vote, and time may be provided during the meeting for each Region to caucus and determine how to cast its vote.

In emergency situations, a meeting may be called by teleconference. Written information may be faxed, transmitted by computer, or mailed and telephone response given.

Section 4.06: Executive Committee

Each Region will vote to appoint one of its members to the Executive Committee of the Council. (See Article VI.) Meetings of this Executive Committee may coincide with Arkansas Mental Health Planning Advisory Council membership events or may occur at other times. (The representative elected by the Region may be the region's chairperson, vice-chair, or another representative voted by the membership.) The term of Executive Committee members will be one year, and a maximum of four consecutive years may be served. Terms shall run from July 1through June 30. The Former State Chair is strongly encouraged to attend and participate in Executive Committee meetings. This is an ex officio non-voting position, unless the State Chair's Region elects to appoint him or her to carry the vote of that Region.

The Executive Committee's responsibility is to discuss emerging problems, to take questions back to their Region for discussion, to bring concerns from their region, and to advise the Director, Division of Behavioral Services in situations where a meeting of the whole Council is not feasible.

At meetings of the Executive Committee, each Region has one vote, and three of the five Regions must have a representative present. The Division of Behavioral Health Services will send written notice to all members of the Council two weeks before the meeting, including notice of the agenda to be discussed and/or questions to be addressed. (Any member of the Council may attend these meetings.) If the regular representative is unable to attend a meeting, he or she may delegate another person to carry the Region's vote: the Region chair, the vice-chair, or another representative voted by the membership.

If a Region is not represented for two consecutive meetings, the State Chair shall notify the officers and others members of that Region, and request that representation be arranged before the next meeting of the Executive Committee. After three consecutive absences, a member of the Executive Committee may be asked to resign from the Committee. However, each absence and circumstance should be considered separately. Before recommending a member be removed from the Committee, the State Chair shall contract the member, consider the circumstances and ask the Committee to vote whether to recommend termination.

In the event of an emergency, a meeting by teleconference may be held. If no representative of a particular Region can attend, a written proxy vote may be sent from the Region to the Chair of the Executive Committee by fax or mail to cast a vote on the issues to be discussed.

If neither representative nor written proxy is sent by one Region, then the Chair of the State Council may cast one vote to break a tie between regions

Section 4.07: Meetings of Regions

Each of the five Regions will use their own discretion in scheduling region meetings. All members are expected to attend meetings of their own Region. After three consecutive absences, a member may be asked to resign. However, each absence and circumstance should be considered separately. Before recommending a member be terminated, the Region shall contact the member, consider the circumstances, and vote whether to recommend termination. Recommendations will be presented to the Executive Committee, who will vote whether to recommend to the Director of the Division of Behavioral Health Services if that person should be removed from the Council membership.

Article V. Minutes of Meetings

Section 5.01: Minutes of Executive Committee Meetings

The Chair of the Executive Committee Council will lead the meetings and ensure accurate minutes of maintained. Meetings shall be recorded and transcribed by support staff of the Division of Behavioral Health Services. Minutes shall be faxed to each member of the Committee for review, and after minutes are approved by the Executive Committee, they shall be mailed by the Division of Behavioral Health Services to all Council members and added to the archive of Council minutes.

Section 5.01a. Minutes of Region Meetings

The Secretary of each Region shall ensure an accurate summary of region meetings is maintained. Minutes of each meeting will be sent to all members of the region, copied to the other members of the Executive Committee for dissemination as needed, and copied to the Division of Behavioral Health Services, who shall maintain an archive of all regional minutes.

Article VI. Election of Officers

Section 6.01 Region Officers

Each Region shall elect a slate of officers for a term to be effective July 1through June 30. Officers shall include a Chair, a Vice-Chair, and a Secretary. A Co-Chair may additionally be elected if the Region prefers to share presiding duties among two individuals during a given term. The Region shall also elect a representative to the Executive Committee, who may be the same person as any of these officers or any other voting member of the Region. It is recognized that some regions may find it efficient to have their Chair also represent them on the Executive Committee, while in other regions no single individual may have time for the combined duties.

Each Region may appoint a Nominating Committee or may accept nominations from the floor at a Region meeting. The current officers of the Region shall educate members as to the general duties and requirements of each office, and communicate with individual members to determine their interest and willingness to serve in various offices. Although no quotas are set, efforts should be made to encourage as many consumers and family members as possible in leadership positions. If a Nominating Committee is used, the additional nominations may be made from the floor at the election meeting. Election shall be by majority vote at a meeting of the Region membership, with notice of the time and place of the voting meeting mailed to all Region members at least four weeks in advance.

The Chair of the Region (or designee) shall report Region activities to the State Chair and the Executive Committee, who will report as needed to the Director of the Division of Behavioral Health Services for information and/or approval.

Section 6.02 Officers of the Statewide Council and of the Executive Committee

State Chair. A Chair of the Arkansas Mental Health Planning Advisory Council will be elected from among the current members in good standing. Nominations may be offered from the floor or by petition, except that no person's name may appear on the ballot until that individual has accepted the nomination. Candidates shall have the opportunity to present statements to the membership, and an election shall be held with each Region casting one vote. Procedures for the election shall be developed by the Executive Committee with the approval of the Director, Division of Behavioral Health Services.

The term of the Council Chair will be two years, and four consecutive years may be served. To coordinate with the schedule of the State Legislature, the term shall begin July 1 of each odd-numbered year and end June 30 of each even-numbered year.

To shift the two-year term to synchronize with this schedule, a special election shall be held for a single one-year term to run July 1, 2002 through June 30, 2003

This Chair will preside over meetings of the statewide Council membership, preside over meetings of the Executive Committee, and carry out such other responsibilities as are requested by the Director, Division of Behavioral Health Services. At Executive Council meetings the Chair shall cast a vote only if needed to break a tie among the Regions voting.

Taking into consideration the abilities, interests, and resources available among the 5 persons serving on the Committee and among other Council members, the Executive Committee or the Director, Division of Behavioral Health Services may assign other specific functions to the Chair as needed.

Chair-Elect/Vice Chair. The election for the next State Chair shall be held one year before the new Chair's term begins. (That is, if the next State Chair is to take office July 1 of an odd-numbered year, then the election shall be held so that he or she can assume the office of Chair-Elect/Vice Chair on July 1 of the preceding even-numbered year.) During this year the Chair-Elect attends meetings of the Executive Committee and generally apprentices to learn the role of Chair and to become familiar with issues currently facing the state mental health system. During this year the Chair-Elect is not a voting member of the Executive Committee, unless he or she has also been selected by his or her Region to carry the vote of that Region.

Article VII. Amendments to Bylaws

Section 7.01

Amendments to these Bylaws may be proposed at any regular meeting of the Executive Committee. The Executive Committee shall appoint and ad hoc committee to review the entire Bylaws and to recommend changes. The ad hoc committee shall prepare a description of changes being proposed, along with a list of all persons who participated in the review and revision. This shall be mailed to all AMHPAC members, along with a notice of date, time, and place that the Executive Committee will vote on the revisions. This notice shall be mailed no less than thirty days before the Executive Committee meeting.

At that meeting of the Executive Committee, any or all of the proposed revisions may be adopted. A majority vote for this purpose shall be affirmative votes from no less than three Regions of the AMHPAC. (That is, regardless of the number of Regions present, a minimum of three affirmative votes are needed, and for this purpose the Chair may vote to break a tie only if the representative from the Chair's own Region is not present.) The revised Bylaws shall be immediately forwarded to the Director of the Division of Behavioral Health Services for final approval.

The State Chair shall ensure that the Bylaws are routinely reviewed at least every two years, if no changes have been proposed in that time.

Article VIII. Committees

Section 8.01 Arkansas Mental Health Planning Advisory Council Committees

The Council shall have the power to establish committees to work on specific topics or issues. The committees can be abolished or created, as needed. Persons who are not voting members of the Council may serve on committees at the recommendation of a region with approval by the State Chair. The committees may include, but will not be limited to (a) Legislative; (b) Education and Community Relations; © Advocacy; (d) Employment and Vocational Rehabilitation; (e) Transportation; and (f) Housing.

Section 8.02: Region Committees

Each Region shall have the power to establish and disband Region committees as needed. Persons who are not members of the Council may participate in these committees, as long as they do not vote in Region deliberations.

TABLE 1. LIST OF PLANNING COUNCIL MEMBERS

(Type of Membership counted in Table 2 is in bold, if more than one type is listed in Table 1 below)

REGION I

Name	Type of Membership	Agency or Organization Represented	Address Phone & Fax
Robert Allured	Family Member of Children w. SED **Therapeutic Foster Care Provider**	**AMHPAC State CHAIR**	4320 Dean Springs Rd. Alma, AR 72921 479-632-3956 FAX – 479-632-3819 raallured@cox.internet.com
Sharon Allured	Family Member of Children w. SED Therapeutic Foster Care Provider	N/A	4320 Dean Springs Rd. Alma, AR 72921 479-632-3956 FAX – 479-632-3819
Cris Arias	Provider	**N/A**	1125 N. College Fayetteville, AR 72703 479-443-5567-Home 479-530-2574-Work 479-713-7187-Fax carias@wregional.com
Sheri L. de Grom	**Family Member of Adult w/ SMI;** Consumer	**Region I Chair**	1208 Lake Street Bull Shoals, AR 72619 870-445-2929-Home 870-445-3365-Office 870-405-0380-Cell sdegrom@cox.net
Tommy L. de Grom	Consumer	N/A	1208 Lake Street Bull Shoals, AR 72619 870-445-2929-Home 870-445-3365-Office 870-405-0381-Cell tdegrom@cox.net
John D. Falkner, Jr.	Provider	Ozark Guidance Center	P.O. Box 6430 Springdale, AR 72766 479-750-2020 ext: 741 John.falkner@ozarkguidance.org
Mae Green	Consumer	N/A	P. O. Box 1025 Mountain Home, AR 72654 870-425-9657-Home 870-424-5779-Fax maeinar@cox.net
John Greer	Provider	Executive Director	P.O. Box 1776

		of Ozark Counseling Services, Inc.	Mountain Home, AR 72654 870-425-6901 ocsadm@centerytel.net
Bobbie D. Hackler	Family Member of Adult w/ SMI	N/A	4317 Hewitt Road Charleston, AR 72933 479-965-7990-Home 479-806-1058-Cell 479-965-7990- FAX bdhack@direcway.com
Lisa A. Huckelbury	Family Member of Adult w/ SMI	N/A	1005 Fir Drive Van Buren, AR 72956 479-471-1385-Home 479-471-8072-Work 479-414-6726-Cell 479-474-1194-Fax Lisah3855@aol.com
L. Gayle Luther	**Family Member of Adult w/ SMI;** Consumer	N/A	905 2nd Terrace Barling, AR 72923 479-883-3507-Home 479-484-1632 ext. 27-Work 479-484-1638-FAX gluther@bost.org
Scott Mashburn, MS	Consumer	N/A	935 N. Highland Avenue Fayetteville, AR 72701-2016 479- 443-9571 s.mashburn@sbcglobal.net
Ellen Mitchell	**Family Member of Child w/SED**	N/A	624 Riverview Place Norfork, AR 72658 870-499-7279-Home 870-405-3395-Cell 1nmitchel@hotmail.com
Darin D. Morgan	**Provider**; Family Member	N/A	P. O. Box 23047 Barling, AR 72923 479-719-9118-Home 479-452-5040-Work 479-353-1669-Message dmorgan@pbhm.com
Barbara M. Neece	Family Member of Adult w/ SMI	N/A	4008 E. Hwy. 45 Fort Smith, AR 72916 479-648-1203-Home 479-648-1203-Fax on request Barb6319@aol.com
George W. Neece	Family Member of Adult w/ SMI	N/A	4008 E. Hwy. 45 Fort Smith, AR 72916 479-648-1203-Home Buzz037@aol.com

Tracy Pennartz	Provider	Associate Director of Western Arkansas Counseling & Guidance Center	P.O. Box 11818 Fort Smith, AR 72917 479-452-6650 ext: 139-Work 479-452-5847-Fax pennartz@wacgc.org
Courtney Lee Pruitt	Consumer	N/A	1331 S. 46th #16 Fort Smith, AR 72903 479-522-2299- Home 479-452-4054- Work 479-522-2299- Message pruittcl@hotmail.com
Marcia Sanders	Family Member of Adult w/SMI	N/A	412 Meyer Drive Van Buren, AR 72956 479-414-3347- Home teach4285@yahoo.com marcias@waesc.wsc.k23.ar.us
Wesley Charles Robbins	Family Member of Adult w/ SMI	N/A	109 South East Avenue Fayetteville, AR 72701 479-751-6277-Home 479-973-2992-Work 479-841-8428-Cell 479-251-9867-Fax wrobbins@dayspringbhs.com
William Don Thompson	Special interest in Children's & Adult Issues	N/A	1105 N Street Barling, AR 72923 479-452-3579-Home 479-452-1361-Fax 479-883-1151-Cell donpoly1869@earthlink.net
Joe Tobin	Consumer	N/A	P.O. Box 1025 Mountain Home, AR 72654 870-425-6957-Message joeinar@cox.net

REGION II

Name	Membership	Agency or Organization	Address Phone & Fax
Mark David Bogart	Consumer	N/A	480 Tortoise Bay Road Higdin, AR 72067 501-825-7667-Home 501-825-6677-Work 501-825-6235- Message
Lon Paul Booker	**Provider**	Families, Inc.	P.O. Box 176 Cherokee Village, AR 72525

			870-257-4938-Home 870-856-3021-Work 870-856-3024-Fax pbokker@familiesinc.net
Janice Falk	**Family Member of** Adult **& Child w/ SED**; Consumer	N/A	HC77, Box 330 Brockwell, AR 72517 870-368-3096-Home Janicefalk72517@yahoo.com
Janice A. Johnson	**Family Member of Adult w/ SMI;** Consumer	N/A	P. O. Box 264 Diaz, AR 72043 870-523-6328
Vonda Boston Keasler	**Family Member of** Adult **& Child w/ SED;** Consumer	Families, Inc.	5511 W. Kings Highway Paragould, AR 72450 870-236-7613-Home 870-335-6881-Work FAX-870-933-9395 familiesvonda@yahoo.com

Region III

Name	Membership	Agency or Organization	Address Phone & Fax
John Allen	**State Representative-Social Services**	Division of Children & Family Services	P.O. Box 1437 Slot S570 Little Rock, AR 72203-1437 John.Allen@arkansas.gov
Bruce M. Cohen	Provider	Director, Office of Special Projects, UAMS Department of Psychiatry	4301 West Markham, #755 Little Rock, AR 72205 (501)312-7662 (501)660-7507 work CohenBruceM@exchange.uams.edu
Vanessa Davis	**State Representative-Mental Health**	Division of Behavioral Health Services, Asst. Director	4313 W. Markham Suite 300 Little Rock, AR 72205 (501) 686-9106 FAX: (501) 686-9182 Vanessa.davis@arkansas.gov
Linda Donovan	Consumer	PEER Specialist Self Direction Committee Chair	2401 N. University Little Rock, AR 72207 (501)663-2135 – Home (501)661-1000 – Work Linda_Donovan4945@msn.com
Andrea Eberle, M.D.	**Provider/** Family Member of Adult w. SMI	Staff Psychiatrist of PCA	1401 Stanphil Rd. Apt. 2026 Jacksonville, AR

			72076 (501)241-2375 –Home (501)982-7515 – Work ajeberle312@aol.com
Georgia Rucker-Key	**Family Member of Children w. SED**	Region III Vice Chair	P.O. Box 45402 Little Rock, AR 72214 (501) 223-2714 home 501/944-2764 Mrucker@sbcglobal.net
Kerry C. Masterson	**Family Member of Adult w/ SMI;** Consumer	N/A	15209 Crystal Valley Little Rock, AR 72210 (501) 455-1200 Home kerrymasterso69@yahoo.com
Karen A. Moix	**Family Member of Adult w/SMI;** Consumer	Disability Rights Center	1100 N. University, Ste. 201 Little Rock, AR 72207 (501) 296-1775 Home (501) 296-1775 Work karenmoix@arkdisabilityrights.org
Michael D. Nash	**Provider**/Family Member/Consumer/ Parent of Consumer	Executive Director of Professional Counseling Associates	P.O. Box Drawer 24210 Little Rock, AR 72211 501-221-1843 FAX – 501-221-2376 Michael.Nash@pca.ar.org
Esther May Poulin	Family Member of Adult w. SMI	**Region III Chair**	7316 Grace Road Little Rock, AR 72209 (501) 562-1571 501-280-0222 fax May_poulin_222@hotmail.com
J.B. Robertson	**State Representative-Education**	AR Dept. of Education	#4 Capitol Mall Little Rock, AR 72201 (501) 682-4354 jrobertson@arkedu.k12.ar.us
William Shumaker	Consumer	N/A	811 Spruce Street Little Rock, AR 72205 rockshoe501@yahoo.com
Susan Perry Simpson	**Family Member of Child w/ SED;** Consumer	N/A	30 Shady Valley Drive Conway, AR 72034 (501) 336-8367
Dr. Melinda Smith	**Provider;** Family Member	LRSD – Education Day Treatment	5300 Halifax Drive Little Rock, AR 72209 (501) 568-5842 Home (501) 447-6355 Work Melinda.Smith@lrsd.org

Joyce Soularie	Family Member of Adult w. SMI	**State Vice Chair**	40 Collins Road Jacksonville, AR 72076 (501) 985-9711 mrmrssoul@msn.com
Rhonda Rouch Strauss	Consumer	N/A	28 Compass Point North Little Rock, AR 72120 (501) 835-3794 Home
Marilyn Strickland	**State Representative-Medicaid**	Division of Medical Services	P.O. Box 1437 Little Rock, AR 72203 (501)682-1671
Mark Sullivan	Family Member of Adult, Consumer	Peer Counselor Volunteer	2500 Kavanaugh 3-C Little Rock, AR 72205 501-663-6026-Home 501-562-5284-Message Mksullivan48@yahoo.com
Jo Ann Sullivan	Family Member of Adult w. SMI	N/A	19 Purdue Circle Little Rock, AR 72204 501-562-5284
Gwendolyn Thompson	Family Member of Children w. SED	N/A	3212 Elam Little Rock, AR 72204 (501) 227-7217 Home gthurston@sbcglobal.net
Moseley Lee Walls	**Family Member of Adult,** Special interest in Children's & Adult Issues	N/A	2500 Willow Street, Apt. 211 North Little Rock, AR 72118 501-771-5559-Home
Sandra Wilson	**State Representative-Housing**	Executive Director, Arkansas Supportive Housing Network	P. O. Box 165858 Little Rock, AR 72216 (501)372-5543
Frank "Mic" Wright	Provider	Senior Vice President, Living Hope Institute	Living Hope Institute 600 South McKinley Suite 400 Little Rock, AR 72205 1-800-829-4673 -Work (501)834-0766 – Home (501)519-2109 – Cell Micw@livinghope.com

Region IV

Name	Membership	Agency or Organization	Address Phone & Fax
Ray A. Brown	**State Representative-Vocational Rehabilitation**	Hot Springs Rehabilitation Service	105 Reserve Avenue P.O. Box 1358 Hot Springs, AR 71902 501-624-4411 FAX – 501-624-4098 R.Brown@ARS.state.ar.us
Esther Burton	**Provider**	Dayspring Behavioral Health Service	297 Bowser Road Monticello, AR 71655 (870) 367-7279 Home (870) 367-2141 Work eburton@dayspringbhs.com
Junie Cumblidge	Family Member of Adult w. SMI	N/A	11001 Donnie Drive Shannon Hill, AR 72103 501-455-2174 501-985-9711-MESSAGE
Karen Kagllerin	Provider	Small Group Work Therapy	311 Whittington Ave. Hot Springs, AR 71901
Kenny Whitlock	**Provider** MH Advocate/Family Member of Adult w. SMI	Executive Director of MHCA	501 Woodland, Suite 220 Little Rock, AR 72201 501-372-7062 FAX 501-372-8039 KennyW@mhca.org
Debra Wilson	Family Member of Children w. SED	N/A	2988 Little Blakley Creek Rd. Jessieville, AR 71949 (501) 984-7679

Region V

Name	Membership	Agency or Organization	Address Phone & Fax
Myra Jarmon	Provider	N/A	1216 Missouri Street Pine Bluff, AR 71601 (870) 536-3958 (870) 447-2008 – Work MJ101756@.com
Shirley Lowe	**Family Member of Adult w. SMI/** Consumer	**Region V Chair**	3509 Walls Rd White Hall, AR 71602 (870) 535-6682 (870) 267-6215

			lowesaf@sbcglobal.net
Bob Parker	**State Representative-Criminal Justice**	AR Dept. of Corrections	P.O. Box 8707 Pine Bluff, AR 71611 870-357-8277 870-247-6326 FAX – 870-247-3700
Evelynn A. Washington	Interested in Adult Issues	N/A	708 Maul Road NW Camden, AR 71701 870-836-5278-Home Evelynn.washington@msn.com

TABLE 2. PLANNING COUNCIL COMPOSITION BY TYPE OF MEMBER

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP	60	
Consumers/Survivors/Ex-patients (C/S/X)	9	
Family Members of Children with SED	10	
Family Members of Adults with SMI	18	
Vacancies (C/S/X & family members)	0	
Others (not state employees or providers)	1	
TOTAL C/S/X, Family Members & Others	**38**	**63%**
State Employees	7	
Providers	15	
Vacancies	0	
TOTAL State Employees & Providers	**22**	**37%**

ARKANSAS MENTAL HEALTH PLANNING ADVISORY COUNCIL

Ms. Pat Dahlgren, Director
DBHS
4313 W. Markham
Little Rock, AR 72205

August 9, 2005

Dear Ms. Dahlgren:

The Arkansas Mental Health Planning Advisory Council (AMHPAC) would like to take this opportunity to share with you the activities that we have been involved in the past FY.

A few AMHPAC members were involved during the legislative session, but AMHPAC did not develop a legislative advocacy agenda. AMHPAC was pleased to see the wealth of activity this year in mental health bills, particularly those pertaining to children's mental health issues.

As you know, all of AMHPAC regions have not been very active in the last few years. As AMHPAC prepared to change leadership on July 1, 2005 an effort was made to try and revitalize the regions. Working toward that goal, training was held for members and perspective members of Region I on May 3rd. The meeting was held at the Jones Center in Springdale, with 14 people in attendance and each of the three CMHC had representatives in attendance. After the training, which covered the Federal law and the duties and responsibilities of AMHPAC a regular Region I meeting was held and officers elected. Region I is currently active and is holding meetings every other month. Each meeting has time on the agenda for training, a report back from the state AMHPAC meetings and time for new business as it arises. Our attention was then turned to Region II. After a discussion with the current members of Region II it was decided that this region while actually functioning as one region would hold meetings as Region II – West and Region II – East. On the 10th of June, Region II - East met at the CMHC in Jonesboro. The meeting was attended by 10 people, 7 were professionals. Then on the 17th of May, Region II – West met in Batesville, also at the CMHC. This meeting was attended by 6 people, of which only 1 was a professional. The same training used in Region I was used in Region II. Officers were elected in Region II. The chair is from Region II – East and the vice chair is from Region II – West. It will be interesting to watch how splitting the region works and if this model will work in other regions. At this time no meetings are scheduled in Regions IV and V. I have met with the Executive Directors of the CMHC's and the State CASSP team and asked them to submit names of individuals in those regions of the state, who might be interested in participating in AMHPAC. The plan is to hold trainings in those areas and to get those regions up and running.

The block grant committee was active again this year and has met 7 times since April 25th. We had significant consumer and family member involvement from around the state.

On August 2nd, the National Association of Mental Health Planning Advisory Councils (NAMHPAC) conducted the first of two trainings around Transformation and Evidenced Based Practices. Judy Stange, NAMHPAC Executive Director and Stephanie Townsend, Judy's assistant were both in attendance. Oscar Morgan was the keynote speaker for this training. Also attending was Melody Reifer, the Director of Consumer Affairs of the Oklahoma Mental Health Authority. The event was attended by over 40 individuals.

AMHPAC looks forward to an active and productive year. Pat, thank-you to you and your staff for your support of AMHPAC activities.

Sincerely,

SIGNED COPY ON FILE
Joyce Soularie, State Chair

ARKANSAS MENTAL HEALTH PLANNING ADVISORY COUNCIL

Governor Mike Huckabee
State Capitol
Little Rock, AR 72201

August 10, 2005

Dear Governor Huckabee,

The Arkansas Mental Health Planning Advisory Council (AMHPAC) is pleased to present the CMHS Block Grant for FY06. The AMHPAC Block Grant Committee has worked with the Division of Behavioral Health Services (DBHS) in producing this document. The Block Grant Committee was made up of consumers, family members and professionals from across the state.

The work of the committee began in April, 2005 and this letter is the final step in fulfilling AMHPAC block grant responsibilities listed in P.L. 102-321. Most of the recommendations that this committee made to the DBHS were accepted by the staff of DBHS. The block grant process was, again this year, a collaborative experience. Part of the recommendations that the committee made was to request two additional staff persons. The committee felt that it would benefit AMHPAC to have a staff person dedicated to planning council state and regional needs. The council also recommended that the DBHS Director Pat Dahlgren add an Office of Consumer and Family Affairs to the current staffing pattern. Due to other issues that have taken precedent, Ms. Dahlgren has not had time to meet with AMHPAC. As time permits the issue of the additional staff will be discussed.

AMHPAC is excited about the new data system that went 'on line' the 1st of July and the opportunities it will hold for the future. Another exciting development of this FY will be the exploring of the transformation process in Arkansas. AMHPAC thanks you, Governor Huckabee, for the involvement of your staff person, Beth Garison in the transformation process. Having her at the table was a valuable asset.

If AMHPAC can be of assistance to you or your staff about the block grant or any other issues concerning the Arkansas mental health system, please feel free to contact us.

Sincerely,

SIGNED COPY ON FILE
Joyce Soularie

PART C. STATE PLAN

I. DESCRIPTION OF STATE SERVICE SYSTEM

OVERVIEW OF STATE'S PUBLIC MENTAL HEALTH SYSTEM

The Division of Behavioral Health Services (DBHS) is Arkansas' Single-State Agency for Mental Health. The Division of Behavioral Health Services is part of the Department of Human Services (DHS), an umbrella agency that includes ten other Divisions responsible for providing social and human services, including those for the developmentally disabled, the elderly, adjudicated youth, and at-risk children and families. Also within DHS is the state's Medicaid Authority agency, the Division of Medical Services. The Director of DHS is appointed by the governor and sits in the governor's cabinet. The Director of DHS, in turn, appoints the Director of DBHS.

Priority populations to be served by the system are: individuals found not guilty by reason of mental disease or defect; individuals assessed as potentially violent; other forensic clients; adults with serious mental illness (SMI) and children/adolescents with serious emotional disturbance (SED). Additionally, to the extent that funds are available, others with mental health problems are eligible for the services of the public mental health system.

The Division of Behavioral Health Services discharges its responsibility for the provision of public mental health services by operating the 202 bed Arkansas State Hospital (ASH) and the 325 bed Arkansas Health Center skilled nursing facility, by contracting with fifteen local, private non-profit Community Mental Health Centers (CMHCs), and certifying (and partially funding) three private, non-profit specialty Community Mental Health Clinics. The Division also contracts with a private, for-profit company to operate a 40-bed, secure residential treatment facility and related aftercare services, to provide integrated dual-diagnosis treatment (mental health and substance abuse) to individuals found not guilty by reason of mental disease or defect. Additionally, DBHS provides training and research support for the system through the Research and Training Institute (RTI) operated in collaboration with the adjacent University of Arkansas for Medical Sciences (UAMS).

Effective July 1, 2003, the state's alcohol and drug abuse authority agency, Alcohol and Drug Abuse Prevention (ADAP), was moved from the state's Health Department to DHS and combined with the former Division of Mental Health Services to form the new Division of Behavioral Health Services. DBHS is, thus, now the single state agency for both public mental health services and public alcohol and drug abuse prevention and treatment services.

AREAS OF PREVIOUS STATE PLAN FOCUS AND RELATED ACHIEVEMENTS

Having data to adequately monitor the public mental health system's performance has been noted as a continuing challenge in the past several block grant applications. During the past year, significant progress has been made in meeting this challenge. DBHS currently collects both client level (Client Data File and Services Data File) and aggregate level data (Basic

Services Program report) from its Community Mental Health Centers and Clinics. The client level data does not contain a unique identifier, so it is not possible to produce unduplicated counts of clients served. Also, for client level data, except for the basic demographic fields of race, gender, age and county of residence, the reliability of the data being collected has not been established, and there is no link between the client and services data fields. The aggregate data collected does provide information for tracking many aspects of the system's functioning, but also does not have unique client identifiers and does not permit breakdown of data into desired subcategories, such as the basic demographic areas just noted. Client satisfaction data is only available through the aggregate data collection system and the instruments used in the surveys vary among the CMHCs. Some improvements in the data systems have been made over the past few years. For SFY 2004, the aggregate collection of adult and child data was integrated and a previous separate data collection system for children's data was eliminated. During this past year, in part with funds provided through the Data Infrastructure Grants (DIG), DBHS has entered into a contract with a private vendor to collect, store and report system wide client and service data. This effort has built on a data collection initiative independently developed through the CMHC's provider trade association, the Mental Health Council of Arkansas. This earlier initiative allowed DBHS to move ahead in developing an improved data system much quicker than would have otherwise been possible. The system being put in place operates through a secure encrypted web-based application. During the past year, contractual issues with both vendor and providers were worked through and data fields and their specifications determined. The system includes unique client identifiers which will allow determination of unduplicated counts served, allow the linking of clients' data with service data, and enable the tracking of clients across the system, including as they move from community care to treatment in the Arkansas State Hospital and vice-versa. Providers have been submitting test data files during the past few months, and the system is scheduled to become operational July 1, 2005. Planning is currently underway to develop enhancements to the system in the next two years that will permit tracking of clients during episodes of local inpatient care, and the tracking of the provision of Evidenced Based Practices (which cannot now be tracked because they are not tied to specific unique billing codes). Client Satisfaction Surveying is also being significantly improved over the aggregated, CMHC-specific system described above. DBHS has contracted with a private vendor with extensive experience in conducting surveys of the state's Medicaid population to conduct a statewide uniform survey with a random sample of sufficient size to yield valid and reliable results. Four hundred returned scorable surveys from each population is required for results reliable at the 95% confidence level. With input from system stakeholders, DBHS decided to use the SAMHSA-recommended MHSIP adult and child/family surveys with the addition to each of items of local interest. A random sample of 1,600 adult clients and 1,600 child/family clients was drawn, yielding slightly over 1,300 valid addresses in each sample. Surveying is currently nearing completion. Already over 500 adults surveys have been returned and over 400 child/family surveys have been returned. Scoring will begin shortly and results will be available in September, 2005.

The significance of Medicaid funding for Arkansas' public mental health system has been noted extensively in previous block grant applications. Medicaid provides approximately 57% of CMHCs' funding, while funds administered through DBHS (state general revenue dollars and federal block grant funds) account for approximately 19% of their funding. The state's Medicaid Authority, the Division of Medical Services (DMS), is a sister Division of DBHS within the

state's Department of Human Services (DHS). DBHS maintains ongoing contact with DMS to work through issues related to Medicaid funding of the public mental health system. DBHS' Assistant Director for Adult Services and Assistant Director for Children's Services each chair a Quality Improvement Committee that oversees the operation of the Medicaid contractor providing prior authorization of services under the state's rehab option plan, Rehabilitation Services for Persons with Mental Illness (RSPMI). Medicaid forwards to DBHS staff for review and comment all proposed policy and procedure changes in this RSPMI program. DBHS senior staff meet with Medicaid staff monthly, or more frequently, to review and provide answers to provider questions regarding the application of these policies and procedures. The focus of greatest mutual concern to DBHS and DMS is the rapidly increasing level of reimbursements under this program in the past few years, particularly for children's services. This increase has been occurring even with the prior authorization programs noted above. Last year's Block Grant application noted that DBHS was exploring with the state's Medicaid authority the possibility of implementing a Medicaid waiver in order to address these issues of appropriate utilization and cost control. This exploration is on-going.

As reported in previous block grant applications, the former Division of Mental Health Services (DMHS) and former office of Alcohol and Drug Abuse Prevention (ADAP) were merged into the Division of Behavioral Health Services (DBHS) effective July 1, 2003. Division level administrative staffs were co-located on October 1, 2003. Also, as noted in previous applications, the staffs from both Mental Health and ADAP worked together to submit a COSIG grant proposal for infrastructure development to provide integrated mental health and substance abuse services. DBHS was informed in the fall of 2003 that it had received this grant in the amount of $1.1 million a year for three years, with lesser amounts in years four and five. Implementation of this grant has been the primary vehicle though which initial steps are being taken to integrate the service delivery systems of these aspects of behavioral health care. The primary focus of the grant is to implement system wide screening for co-occurring disorders, with the goal being that all mental health (MH) providers will use a common instrument to screen for substance use disorders and all substance abuse (SA) treatment providers will use a common instrument to screen for mental health disorders. The grant has supported planning and training activities attended by both mental health and substance abuse providers. There have been some reports of enhanced communication, referral and cooperation between SA and MH providers resulting from these joint activities. Plans are also underway to link the MH and SA data system (each using SSN as common unique identifiers) so as to be able to track client movement between the systems.

Last year's plan noted the DBHS priority of beginning to move the system to greater availability of evidenced-based practices (EBP). The COSIG grant activity to develop the infrastructure to provide integrated treatment for co-occurring substance abuse and mental health disorders (described immediately above) is one aspect of carrying out this priority. Assertive Community Treatment (ACT) is the EBP that DBHS has had the longest standing and most direct financial role in supporting. DBHS funded the start-up and initial several years of operation of the state's first ACT program (GAIN). Over time, as has been the case with other elements of the public mental health system, GAIN moved to greater reliance on Medicaid for its funding. However, DBHS continued to provide some state general revenue funding to GAIN to support the provision of ACT services for individuals without Medicaid, especially such individuals with

multiple Arkansas State Hospital admissions The level of funding to GAIN had remained constant over the past several years and with increased costs, the case rate was no longer adequately funding the services provided. DBHS is increasing its funding to GAIN for SFY 2006 to support an increased case rate. The community providers in the public mental health system, Community Mental Health Centers and Clinics (CMHC), are all independent, private, non-profit organizations. Some of these CMHCs have undertaken the development of EBPs on their own initiative, without DBHS mandate or financial support, although with DBHS informal encouragement and technical support. In this manner, three additional ACT programs have been developed, including one starting up within the past year. Similarly, several CMHCs have implemented Supported Employment programs without direct financial support from DBHS. EBPs for children include therapeutic foster care programs operated by eight of the fifteen CMHCs for children with serious emotional disturbance in the custody of the Division of Children and Family Services. As noted in last year's plan, DBHS plans to systematically survey the implementation status of all EBPs across the system. The draft of this survey has been developed and reviewed by some staff in the field. DBHS does note that there are significant definitional issues to be addressed in the survey, in particular, with being able to specify a required level of model fidelity and being able to distinguish between programs providing EBPs versus aspects of some EBPs (such as Illness Management and Recovery) that have become part of routine clinical care. DBHS anticipates conducting this survey in the first quarter of SFY 2006 and being able to cite results in the 2005 Implementation Report.

As noted in previous years' Adult Plans, developing capacity and access for local acute inpatient care has been a significant problem facing the adult system of care. The origin of this problem was described in last year's plan. In response to the need for more acute care capacity, the state legislature appropriated $5.8 million for SFY 2004. DBHS initiated a local acute care program in November of 2003. Funding for this program was increased to $9.3 million for SFY 2005 and has been increased to $11,550,000 for SFY 2006. During this past year, the primary focus has been on addressing ongoing operational implementation issues of this program. Funds are distributed to CMHCs on an adult per capita basis. During SFY 2005, this program paid for 12,154 days of local inpatient care admissions. CMHCs contract with local hospitals for this care and serve as the point of access to this service, and as the utilization managers of the benefit. The CMHCs also provide alternatives to inpatient care when this is possible, and provide the aftercare when those hospitalized are discharged.

As in the previous Children's Services Plan, monitoring Medicaid-funded mental health services for the under-twenty-one population has continued to be an important issue for the children's mental health system of care. DBHS works closely with the Division of Medical Services (DMS) and the Medicaid utilization management company, APS Healthcare, to advocate for system changes to improve accessibility, availability and accountability of outpatient services for the Medicaid population. DBHS and DMS included a component to the utilization management contract to provide "Care Coordination" to assist in transitioning children from inpatient services to community-based services. The DMS contract for SFY 2006 will increase the level of care coordination for Medicaid eligible children. The purpose of Care Coordination is to assure that services occur in the least restrictive setting and contain an appropriate array of community-based services at the necessary level of intensity. Care Coordinators follow children that fall into

"outlier" categories of children, who have received inpatient services. Examples of these categories include recipients under the age of six years, recipients that have had two or more hospitalizations in a year, and recipients with length of stay exceeding six months in residential treatment. Care Coordinators insure that children with serious emotional disturbance are referred for CASSP local service teams that are coordinated by each CMHC for multi-agency plans of service (MAPS). From October of 2003 through March of 2005, a total of 226 children received care coordination from APS. As a result, MAPS have been developed for 65 children statewide. APS will continue to provide data to DBHS on systems issues, services, gaps in service, and strengths and weaknesses in the mental health field. Issues that have been brought forth in the past year include the need for specialized services for the dually-diagnosed population (mental health/substance abuse and mental health/developmentally disabilities), better coordination and communication between inpatient and outpatient services, and the need for more intensive case management for children in the custody of DCFS. The Division of Behavioral Health Services chairs a Quality Improvement Committee that meets regularly to provide input to the State on Medicaid utilization management and other issues that impact the system of care.

The CASSP Coordinating Council has continued its focus on early childhood as a priority population over the past year. The DHS Division of Child Care and Early Childhood Education (DCCECE) and the Arkansas Head Start State Collaborative Project are working with DBHS on an initiative to implement evidence-based prevention, early intervention and treatment services for young children, birth to eight years of age. DCCECE funded a series of trainings for CMHC mental health professionals. DBHS has a contract performance indicator for the CMHCs to appoint an early childhood liaison that would participate in training provided by the state and produce a specific plan for early childhood services in each catchment area for SFY 05. As a result, each of the CMHC's have clinicians trained in assessment and treatment of the young child and consultation with child care providers. Fourteen of the CMHC's have at least one clinician certified in administering the Devereux Early Childhood Assessment – Clinical (DECA-C). These training sessions have accomplished the goal of increasing the level of expertise for this population on a statewide basis. Three pilot projects, funded by DCCECE, for early childhood mental health consultation by CMHCs for licensed childcare programs were awarded and implemented in the past year. A contract for an independent evaluation has also been awarded to monitor and report outcomes of these projects. Training in early childhood mental health will continue over the next year, along with monthly conference calls for all CMHC early childhood liaisons that focus on sharing information and technical assistance that address topics from systems issues to case-specific interventions. This collaborative endeavor has been an important partnership that will strengthen the public mental health system.

School-based mental health services are another priority for DBHS. All community mental health centers provide school-linked or school-based services. Most of the CMHCs are planning to increase these services for the next school year. DBHS and the CMHC's are continuing to collaborate with schools and the Department of Education/Special Education in an effort to have a consistent approach in school-based mental health programs within the Arkansas public school system. School-based mental health services were expanded with the block grant increase from FY04. These dollars were awarded in five grants to CMHC/school partnerships around the state. DBHS and the Department of Education combined funding to expand School-Based Mental

Health Programs by CMHCs. Two of the grants were awarded a CMHC partnership with schools for special-needs populations, the School for the Deaf and the School for the Blind.

NEW DEVELOPMENTS AND ISSUES AFFECTING THE MENTAL HEALTH SYSTEM

DBHS has been notified that, in the upcoming state fiscal year (SFY) starting July 1, 2005, an additional $2,250,000 will be available for the local acute care program described above, bringing the total funding for the program to $11,550,000. DBHS is continuing to allocate these funds to CMHCs on an adult per capita basis. However, the legislation granting this funding increase also mandates that DBHS work with CMHCs to develop an equitable acute care distribution plan which considers utilization of State Hospital beds, clarifies target population and other pertinent demographic factors to ensure maximum equitable utilization of public funds. DBHS is required to report this distribution plan to the Legislative Council by July 1, 2006. Some CMHCs have exhausted the funds made available to them for local acute care without meeting all the demand for local inpatient care presented by the residents of their catchment area. Some of these Centers present that they are serving a higher risk population and should, therefore, be allocated more funds. Some Centers not exhausting funds in this program to pay for local inpatient care contend that this results from their effective crisis intervention work and other diversion activity financed from the savings not spent on inpatient care. These Centers contend that cutting any funding to them in this program would result in a curtailment of these diversion activities and bring about an increase in hospitalization. Some local hospitals operating inpatient psychiatric units also question the distribution formula, the terms of the contracts under which it is distributed and the enforcement of the contract terms. These hospitals generally present that they are unfairly put in a position of absorbing indigent care costs.

Ongoing developments in Medicaid, (the largest funding source for services in the state's public mental health system), continues to present issues that significantly affect the mental health system. Medicaid expenditures for mental health services have continued to increase in recent years. Under the rehab option RSPMI program, Medicaid expenditures for SFY 2004 were up 12% over SFY 2003; SFY 2003 expenditures were up 12% over SFY 2002 which, in turn, were up 28% over SFY 2001. The increases were most dramatic in children's services where the increases were 15% form SFY 2003 to SFY 2004, 13% from SFY 2002 to SFY 2003, and 50% from SFY 2001 to SFY 2002. This increase is primarily a result of the expansion of the provider pool beyond the CMHCs to include both other non-profit providers and for-profit providers. The unfortunate result has been to increase the percentage of indigent clients for the CMHCs with more private providers providing services for clients with Medicaid reimbursement. DBHS is also tracking the impact on the workforce within the public mental health system as a result of more mental health professionals being hired into the private sector. Although increased Medicaid spending has the positive effect of providing more services to more clients, the increases also jeopardize future funding of the program if there are future state budget shortfalls or other state budget priorities. There is also the issue of ensuring that the funding available is being used for those most in need and that, when possible, services are being provided in the community rather than inpatient settings. As noted in last year's plan, in order to address these issues of appropriate utilization and cost control, DBHS is exploring with the state's Medicaid authority the possibility of implementing a Medicaid waiver. This exploration continues.

DBHS' Central Administrative Offices and the Arkansas State Hospital sit adjacent to the University of Arkansas for Medical Sciences (UAMS) in Little Rock. DBHS has recently entered into an agreement with UAMS to deed to it a portion of the grounds on which its facilities sit in exchange for UAMS having constructed for DBHS a new State Hospital facility. This will be part of a larger building project by UAMS to expand its teaching hospital and related facilities. The new State Hospital will have the same number of beds as in the existing facility, however, it will be a new modern facility providing a nicer environment for patients and staff and will be much better configured to support the hospital's active treatment model. Also, as a part of its expanded hospital, UAMS will open a 40 bed acute psychiatric inpatient unit. These beds will be an additional response to the above noted need for local acute care beds.

During the past year, ASH has been the subject of investigation of allegations of patient abuse by the state's Disability Rights Center (DRC). ASH management has acknowledged instances of failure to following established procedure in investigating allegations of abuse. ASH is in the process of developing and implementing corrective action plans to address these issues. DRC indicates that it plans to continue to monitor activity at ASH.

The initiation of the Medicare Part D prescription drug benefit is anticipated to have a significant impact on the public mental health system, particularly for those individuals with both Medicare and Medicaid (dual-eligible). These individuals currently have their prescriptions paid for by Medicaid with only a nominal co-payment. It is our understanding that most of these individuals will be eligible for "Extra Help" and that many will be deemed eligible for this help and automatically enrolled for the extra help so that, in effect, their cost of getting prescription drugs will remain the same. DBHS is appointing a senior staff member to coordinate a system wide training and education approach to be able to accurately inform clients about this new program and give them assistance in taking any needed enrollment and/or plan election decisions. At this point, plans include arranging for a general orientation and overview of the program at the annual Mental Health Institute. This will be followed-up with a one or two-day Train-the-Trainer session for CMHC case manager supervisors who will, in turn, train the case managers at their Centers.

In the most recent session of the state General Assembly, legislation was passed that merged the State Health Department with the Department of Human Services (of which DBHS is a division), creating the Department of Health and Human Services. This merger takes place during SFY 2006, with Central Administrative functions, such as personnel and accounting, being the initial focus of the merger. DBHS currently has a working relationship with the Department of Health, however, it is anticipated that the merger will strengthen this relationship and facilitate cooperative efforts. Future possible implications of this merger include a greater focus on the "public health" aspects of mental health and a greater integration of mental health and physical health care. As noted elsewhere, at DBHS' request, the State Department of Health has agreed to consider including optional module PHQ 8 (a measure of the prevalence of anxiety and depression) in its next Behavioral Risk Factor Surveillance System (BRFSS).

DBHS' new, enhanced data system, going online July 1, 2005, has been referenced and described in several other sections of this plan. DBHS anticipates that the new system will permit better monitoring of system performance, including revealing aspects of the system that

could benefit from quality improvement initiatives. The new, enhanced system will, in turn, allow tracking of the results of these initiatives.

LEGISLATIVE INITIATIVES

The Arkansas State Legislature met in regular session January through May of 2005. The Legislature provided some funding increases to DBHS. Local Acute Care Funding, including funds to be used by local CMHC's to purchase local inpatient psychiatric care was increased twenty-four percent from $9,300,000 to $11,550,000. General program support to CMHCs was increased 4.75% from $8,381,881 to $8,780,603. The Arkansas State Hospital received approval to pay nurses enhanced shift differentials so that it can be more competitive with other area hospitals. DBHS did not receive requested funding to assist in the upgrade of ASH's management information system, however, some system improvements are being funded from other program savings.

As a result of increased interest by the legislature's Children and Youth Subcommittee in children's mental health issues in the past year, the following laws were passed during the 2005 session that impact the children's mental health system.

1. Act 1958: An Act to Amend Reporting on Emotionally Disturbed Youth. This law requires Arkansas to collect much needed data regarding the in-state and out-of-state placement of children in psychiatric programs funded by Medicaid. DHS is required to provide a detailed monthly report to the House Interim Committee on Aging, Children and Youth, Legislative and Military Affairs and the Senate Interim Committee on Children and Youth.
2. Act 2079: An Act to Make Appropriations for CASSP. For the first time since CASSP was established in 1990, an appropriations bill was passed which could provide four million dollars to DBHS for CASSP. This funding is outside the revenue stabilization requirements and will only be appropriated if funding is found outside of the current approved state budget.
3. Act 1959: An Act to Ensure the Continuity of Mental Health Services for Juveniles in Their Communities; To Address the Out-of-State Placement of Children for Mental Health Services and Treatment; To Clarify the Requirements for an Assessment or Screening. This is a new law written to help ensure that children receive mental health services in their communities whenever possible, and in the least restrictive placement consistent with their needs. It requires DHS to assess any child that is ordered by a juvenile court to any out-of-state inpatient mental health services to determine the appropriate level of care necessary.
4. Act 2209: An Act to Create the Comprehensive Children's Behavioral Health System of Care Plan. This law provides for increased representation of private providers on the CASSP Coordinating Council. It also designates DBHS as the state agency responsible for the coordination and oversight of a Comprehensive Children's Behavioral Health System of Care Plan. All state agencies that receive funding, either state or federal, that supports behavioral health services, are mandated to participate in collaborative planning for the system of care. It requires that in July, 2005, collaborative agreements must be established between DBHS and all other state agencies regarding responsibilities for the development and implementation of the System of Care Plan. It also requires that all agencies provide all pertinent information to

DBHS, including expenditures and programming data that is necessary to develop the plan, which must be completed by April, 2006.

REGIONAL PROGRAMS: COMMUNITY MENTAL HEALTH CENTERS

Services are provided statewide through contractual relationships between DBHS and 15 certified community mental health centers (CMHCs) situated throughout the state. All of these CMHCs are private, non-profit organizations with local Boards of Directors. All CMHCs are accredited by either CARF or JCAHO. Each CMHC serves a designated geographic catchment area, and have service sites in 69 of the state's 75 counties. The CMHCs provide a full range of services (as mandated by law), which are described in detail under various criteria in the State's Plan. In SFY 2004, these CMHCs served 74,056 mental health clients, of which 49,803 were adults and 24,920 where children. This number represents a slight increase over SFY 2003 when 72,821 were served, of whom 48,500 were adults and 24,458 were children. The CMHS Uniform Reporting System: 2003 State Report indicates that Arkansas' system of community services has a higher penetration rate than the national average (25.83 vs. 17.56 per 100,000) and a lower rate of utilization of State Hospital beds 1.01 vs. 1.07 per 100,000). On the other hand, as a percent of its total expenditures the State Mental Health Agency expenditures on community services are lower than the national average (32% vs. 49%). Some caution is warranted in making comparison of any state with the national average since states vary in the populations served by their public system and in the structure of the systems financing, in particular whether or not Medicaid funds are controlled by the State Mental Health Agency, as they are not in Arkansas.

The CMHCs are the single-point-of-entry to the public mental health system. Once admitted to the system, the CMHC maintains responsibility throughout the course of treatment. Entry into the Arkansas State Hospital or to state-funded local inpatient care is also through the CMHC, and the CMHCs provide aftercare when these individuals are discharged from the hospital.

In addition to the 15 CMHCs, DBHS also certifies three specialty Community Mental Health Clinics and contracts with a private, for-profit company to operate a program for those found not guilty by reason of mental disease or defect who have co-occurring mental illness and substance abuse disorders. The clinics are all private, non-profit organizations, and are accredited by either CARF or JCAHO. These specialty clinics provide programs for persons with severe and persistent mental illness who require intensive levels of service. These clinics accept referrals from throughout the state, including from the CMHCs.

DBHS LEADERSHIP ROLE

DBHS' formal leadership role is exercised through its participation in the executive functions of state government, particularly within the Department of Human Services. Within DHS, and through DHS to the governor's office, the Director and other senior staff of DBHS advocate for the needs of the public mental health system. This includes both policy and budget advocacy. This advocacy is carried out in both regularly scheduled and ad hoc meetings of DBHS senior staff with the leadership of DHS, and occasionally meetings with the staff of the governor's

office. There are also frequent meetings, particularly on budget and personnel matters, with other executive departments of state government such as the Department of Finance and Administration.

Within DHS, DBHS staff is active in advocating for the public mental health system and bringing its expertise to the table with other DHS Divisions, such as the Division of Developmental Disabilities, Division of Family and Children Services, Division of Youth Services and Division of Adult and Aging Services. Staff of DBHS meet frequently with staff of these other DHS Divisions involved with providing public human services, many of which have mental health components.

The most important DHS Division with which DBHS works is the Division of Medical Services (DMS), the state's Medicaid agency. As noted elsewhere, more funding of public mental health services actually flows through DMS than through DBHS. DBHS has developed a good working relationship with DMS. The Directors of the two Divisions are in frequent contact and senior staff of the two Divisions meets regularly, with several meetings a week not being uncommon.

DBHS also involves itself with other Departments of state government when issues of public mental health services are on the table. The Departments with which DBHS is most frequently involved include the Department of Education (which includes the state's Division of Vocational Rehabilitation Services), Department of Correction, and the Arkansas Development Finance Authority (housing).

Act 2209 of 2005 designates DBHS as the state agency responsible for the coordination and oversight of the Children's Behavioral Health System of Care Plan that is to be completed in April of 2006. This legislation formalizes the leadership role of DBHS, requiring collaboration and data sharing by all other state agencies. This Act puts DBHS is a position to be more effective in providing vision and direction for the State regarding the children's behavioral health system of care.

In addition to its formal role of leadership on public mental health issues within state government, DBHS meets, consults and allies itself with other organizations to advance the cause of public mental health. This includes involvement with the Arkansas Mental Health Planning and Advisory Council (AMHPAC), the Mental Health Council of Arkansas (the CMHCs trade association), The University of Arkansas for Medical Sciences (especially its Department of Psychiatry), NAMI-Arkansas and the Arkansas Hospital Association.

II.a. IDENTIFICTION AND ANANYSIS OF THE SERVICE SYSTEM'S STRENGTHS, NEEDS, AND PRIORITIES-ADULT MENTAL HEALTH SYSTEM

COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SYSTEM

The primary strength of the adult comprehensive community-based system of care is the existence of a well established, stable group of public mental health providers- the 15 CMHCs and three Mental Health Clinics. These 18 providers have all been serving their communities (CMHCs) or special populations (Clinics) for at least 15 years, and many have been providers for over 30 years. These providers, with local boards of directors, generally have high visibility in their communities and broad community support. From the point of view of clients, especially those with severe and persisting mental illness, the CMHCs and clinics provide for continuity of care over extended periods of time. All of the CMHCs provide the basic array of crisis intervention/stabilization, clinical and rehabilitative services (described in detail below).

As noted in last year's plan, the breadth of services within the basic array varies among Centers, and with few exceptions evidenced-based practices (EBP) with known fidelity to the practice model are not in place. For example, all providers offer some type of intensive case management to clients with a history of extensive previous inpatient care and high risk of relapse, however, only four have established formal Assertive Community Treatment Programs intentionally following the EPB model. All providers offer 24-hour crisis intervention/stabilization of some type, but only four operate a residential crisis stabilization unit in which a client can reside overnight if needed. All providers offer some type of assistance with housing and employment. However, this varies from assessment and referral for services, to providers operating an extensive range of housing options or offering in-house staff dedicated to providing supported employment. All Centers provide services to the dually-diagnosed (mental health and substance abuse), but these range from coordinating services with a separate substance abuse provider to offering in-house integrated dual-diagnosis treatment.

The service system need, and a continuing priority for DBHS, is that Evidenced Based Practices be more widely available throughout the service system. DBHS funded the start-up of the state's first Assertive Community Treatment program. This program has indicated that it will require an increase in funding to offset increased costs for next year to prevent a decrease in program capacity. It is a priority of DBHS to at least maintain, if not increase, the capacity of this program. Since the last plan was submitted, the number of ACT programs in the state has increased from two to four. One of the two new programs receives some of its funding from DBHS. DBHS also provides some of the funding for a small program that provides integrated mental health and substance abuse treatment for individuals found not guilty by reason of mental disease or defect.

In recent years, DBHS has been successful in two grant applications related to implementing EBPs. It received a three-year $100,000 per year planning grant related to implementing standardized pharmacological treatment, and it received a three-year $1.1 million COSIG grant (with lesser amounts in years four and five) to develop the infrastructure for implementing integrated treatment for those dually-diagnosed with mental health and substance abuse disorders. The standardized pharmacological planning grant has been partially implemented. A

stakeholders' advisory committee was formed, providers were surveyed and focus groups of providers and consumers were conducted. Contrary to initial expectations that poly-pharmacy would be identified as the area of greatest need, access to medications has been identified as the most pressing issue to be addressed. The planning effort will now focus on this issue. As noted above, the primary focus of the COSIG grant has been to implement system wide screening for co-occurring disorders with all mental health (MH) providers using a common instrument to screen for substance use disorders and all substance abuse (SA) treatment providers using a common instrument to screen for mental health disorders. The grant has supported planning and training activities attended by both mental health and substance abuse providers. There have been some reports of enhanced communication, referral and cooperation between SA and MH providers resulting from these joint activities. Plans are also underway to link the MH and SA data system (each using SSN as common unique identifiers) so as to be able to track client movement between the systems.

A significant issue DBHS faces in promoting the initiation and dispersal of EBPs is difficulty in tracking their implementation, including counting how many individuals are receiving EBPs. This, in turn, is partly related to difficulties in defining EBPs. The challenges in applying EBP definitions have been noted in the process of implementing the CMHS data infrastructure grants (DIG). While DBHS has provided some leadership in the limited implementation of some EBPs, some CMHCs have developed EBP practices or elements of EBPs on their own initiative. However, the extent of this development of EBPs through local initiative has not been systematically tracked. For example, CMHCs report to DBHS on both employment and housing services they provide to clients. However, with the current reporting system, it is not possible to determine the extent to which any of these services meet EBP guidelines and, hence, how many clients are actually receiving EBPs in these areas (supported employment and supported housing). Tracking EBP is further complicated by the fact that they are not systematically and uniquely associated with specific billing codes. It is a priority of DBHS to determine the current level of implementation of EBPs across the system and to be able to track the numbers of clients receiving these services.

While seeking to promote the implementation of EBPs it is also important to monitor and support the maintenance of current practices that support the goals of a community-based service system. A basic goal of this system is that inpatient psychiatric hospitalization be kept to a minimum. This goal is particularly supported by an assertive aftercare program for those being discharged from the state hospital and an extensive case management system that includes taking the services to the client.

MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY

The state of Arkansas uses the federal definition to identify persons with a serious mental illness (SMI). During SFY 2000, DBHS developed an operational definition of serious mental illness and instituted a physician certification procedure to identify those meeting the federal criteria. The new procedure was phased in during the last quarter of SFY 2000. Since then providers report semi-annually on the number of individuals with a serious mental illness who are served. This reporting does not have unique client identifiers that allow determinations of unduplicated

numbers served. The reporting is an aggregate report, rather than client level, and thus it is not possible to partial out subgroups of persons with a serious mental illness who are served on such criteria as gender, race or ethnicity. Developing a system that will permit this detailed level of tracking is a priority of DBHS.

In addition to tracking the number of individuals with a serious mental illness served, DBHS tracks a subgroup of this population that receives case management and, as needed, other community support services. This group would typically meet the definition for severe and persistent mental illness (SPMI). However, with the adoption of the federal definition of SMI, there has no longer been a standardized method for identifying this SPMI population that needs case management and other community support services. The current identification of this population is by clinical functional assessment using methods and definitions adopted by each provider. In addition to questions of reliably raised by this process, Medicaid utilization patterns are raising the possibility that some more uniform method may need to be instituted to identify this population. When Medicaid was initially tapped in the 1980s as a primary funding source for public mental health services, the predominant recipients of services were adults with SPMI, and there was a package of community support services that were restricted to this population. With the adoption of the federal SMI definition by DBHS, eligibility for this restricted package of services in effect was extended to a broader population. Also, over time an increasing number of non-SMI adults have been receiving services in the public mental health system, including those with Medicaid as a funding source. As noted above, those with serious mental illness are among the priority population to be served by public mental health system providers, and others identified as priority populations (individuals found not guilty by reason of mental disease or defect; individuals assessed as potentially violent; other forensic clients) would, in almost all instances, meet the federal definition for having a serious mental illness. However, as also noted, all others needing mental health services are eligible for public mental health service "to the extent resources are available" after meeting the needs of the priority populations. Increases in Medicaid expenditures for public mental health services have been noted above. DBHS is working with Medicaid to control costs and ensure appropriate utilization of services. In part, these efforts may need to include adoption of some uniform definition of and method of identifying the population with SPMI that would be eligible for a restricted package of services. Similar issues are raised by the use of the federal definition of Serious Emotional Disturbance (SED).

With the limitations noted above, DBHS is able to track penetration rates of numbers of persons with SMI served as a percent of the total federal estimated prevalence. However, it is not able to track unmet need since it does not currently have an estimation of the number of persons with SMI who are in need of service during any particular time period, nor the number of these individuals that are receiving needed care outside the public system.

TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS

A strength of Arkansas' public mental health system is that a number of providers have housing programs, some quite extensive. To the extent these housing options are available, homelessness of at-risk individuals with serious mental illness can be averted. CMHC-controlled housing

options are also readily available to individuals with serious mental illness who have become homeless. DBHS has a staff member that devotes a significant portion of her time to assisting CMHCs and other providers in developing housing options. Another strength of the system is the use of a competitive RFP process for distribution of PATH funds. This process, in part, depends on demonstrating need and helps focus the use of funds where they are most needed and will be most efficiently utilized. DBHS has allied with other smaller states to attempt to secure increases in PATH funding. This effort is ongoing and is a DBHS priority.

All services of the public mental health system are potentially available to homeless individuals with serious mental illness, however, access to these services is frequently problematic. CMHCs with PATH grants have dedicated outreach efforts to the homeless. For all CMHCs, access of the homeless to services is frequently through its crisis intervention/stabilization program.

Being a rural state, Arkansas' public mental health system was developed to serve this population. Although becoming somewhat more urbanized, Arkansas continues to have a significant rural population. The state's CMHCs are disbursed around the state, frequently with headquarters in a rural community. Service sites are even more disbursed, being in 69 of the state's 75 counties. Even those few counties without a Center-operated service site, have services delivered there through off-site case management and other off-site programming such as services provided in local schools, human service agencies or correctional facilities. Some CMHCs also use an extensive transportation system to help reach the rural population.

It is challenging to bring certain services to the rural population, especially those where efficiency depends, in part, upon economy of scale. This issue, for example, has presented barriers to extending Assertive Community Treatment in rural areas.

MANAGEMENT SYSTEMS

Financial Resources

The public mental health system in Arkansas has grown increasingly dependent on Medicaid as its primary funding source. In SFY 04, the Community Mental Health Centers and Clinics had revenues from Medicaid of approximately $100 million. This compares with approximately $32 million in revenue from DBHS-controlled funds, including the approximately $4 million federal block grant. Access to Medicaid funds has had the positive effect of greatly expanding the financial resources available to the system beyond what could have been possible depending on state general revenue funding distributed through DBHS. However, the system is also vulnerable to potential Medicaid funding shortfalls, and, to some extent, public mental health policy is more influenced by the state's Medicaid agency, the Division of Medical Services (DMS), than by DBHS.

DBHS has developed a good working relationship with DMS, and is regularly consulted with on mental health issues by DMS. The senior staff of DBHS and DMS meets on an ongoing frequent basis. DBHS is currently exploring with DMS the possibility of a waiver under which DBHS would assume responsibility for Medicaid funds expended on public mental health services.

Although such an arrangement would present some risk to the DBHS budget, it would give DBHS the final say in policy for the most significant funding source for public mental health service.

General revenues and other support to the public mental health system through DBHS have remained relatively constant for the past several years. However, the 2005 legislature provided for an increase of $2,225,000 for the local acute care program for SFY 2006. There was also a 4.75% increase in general program support to CMHCs.

Staffing Resources

The number of budgeted staff positions at CMHCs increased for SFY 2005 to 2,898 from 2,528 budgeted for SFY 2004. However, most of this increase (283 of 370) is accounted for by adding into the total for SFY 2005, the staff of an affiliate of one the CMHCs whose numbers had not been included in previous year reports. Without this affiliate, the increase is three percent, which approximately parallels the increase in the number of clients being served. There are anecdotal reports of significantly higher salary levels being paid in the for-profit sector attracting away staff from the public system, which presents the prospect of erosion of staff resources available for the public mental health system. DBHS was successful during the past year in getting Medicaid to accept Advance Practice Nurses with pyschiatirc specialities as recognized providers of medication management services reimbursable under the RSPMI program.

Training Resources

A significant strength of the public mental health system is the annual behavioral Health Institute, of which DBHS is a major sponsor, including a $10,000 grant funding allocated from the federal block grant. This Institute has been held annually for the past 32 years and, in recent years, has drawn over 1,000 participants to a wide variety of training opportunities.

Although the Institute has provided a number of training opportunities related to evidenced-based practices, much more extensive training will be required to make these practices more widely available throughout the system. As noted in last year's plan, a step in this direction is provided by the recently awarded State Incentive Grant for Treatment of Persons with Co-occurring Substance Related and Mental Disorders (COSIG grant) that has a significant training component related to screening and assessment of co-occurring mental and substance abuse disorders. Several related training sessions were conducted this past year.

With the initiation of Medicare Part D, DBHS is anticipating the need to train a large segment of the CMHC staff in the details of this benefit and its application, especially to the dual eligibles covered by both Medicare and Medicaid. DBHS is coordinating a presentation on this topic at the Mental Health Institute and plans to also sponsor even more extensive train-the-trainer sessions for Community Support and Case Management Staff.

II.b. IDENTIFICATION AND ANALYSIS OF THE SERVICE SYSTEM'S STRENGTHS, NEEDS, AND PRIORITIES-CHILDREN'S MENTAL HEALTH SYSTEM

The vision of the Division of Behavioral Health Services, as well as other mental health stakeholders, is to strengthen the children's mental health system by effectively serving and supporting children and their families. Priorities have been set that include passage of key legislation in the 2005 legislative session, changes in policy, and planning and implementation of services and programs that move more responsibility and decision making to the local level. DBHS continues to focus on forming partnerships with stakeholders and families who can help identify the needs of each community, and define what the system of care for children and adolescents with serious emotional disturbance and their families should look like through a continuum of care that combines traditional services, preventive services and specialized services.

- The CASSP Coordinating Council has identified goals to increase consistency and quality in the CASSP process on a statewide basis for Service Teams, Regional Planning Teams and the Coordinating Council. These goals will help to ensure that the CASSP process functions according to legislation, and that the Division of Behavioral Health Services, as the coordinating agency, increases accountability and support for CASSP on a statewide basis.

- The CASSP Coordinating Council has recently verified appointments and re-appointments of 44 positions for the 2005-2006 state fiscal year. The Directors of the Departments of Human Services, Health and Education made these appointments. Revised CASSP legislation has increased the involvement of a wide array of stakeholders in children's mental health issues, and has increased the quality of the Council's actions.

- The Executive Committee continues to meet at least monthly to work on issues identified by the full Council, and has provided strong leadership and focus on issues that have recently impacted the children's mental health system.

- The Coordinating Council publishes a CASSP Newsletter and Report Card to raise awareness about CASSP and current children's mental health issues in the state. This newsletter and report card are included as part of the quarterly report to the Children and Youth Subcommittee of the Arkansas Legislature.

- Coordinating Council members work individually on various committees and task force groups to help improved the system of care for children and families. Council members participated in the Children's Mental Health Workgroup, chaired by a state representative. The issues identified by this group closely relate to the major issues identified by the CASSP Coordinating Council.

- The CASSP Coordinating Council has led the effort to expand services aimed at early identification and treatment for the needs among younger children before those needs escalate to a level of "severe" disturbance. This effort has required the building of new collaborative partnerships with several types of expertise such as pre-school and day care

providers, Head Start programs, pediatricians, family physicians and other public health entities.

- The CASSP Coordinating Council has updated the "Children's Mental Health Services in Arkansas" CASSP Position Paper and developed a Position Paper brochure.

- School-based Services have been developed and expanded through partnerships between the community mental health centers and school districts with some funding from the Division of Behavioral Health Services. These initiatives have proven to have positive outcomes for the children and the schools involved. Some community mental health centers in collaboration with the Department of Education have also joined a network of providers to do evidence-based school-based mental health services.

- The Division of Behavioral Health Services has worked closely with the current utilization management system to improve services for the U-21 Medicaid population and insure that outcomes are consistent with the CASSP system of care principles. Care Coordinators have been utilized in the community to work closely with each community mental health center to prevent children in need of services from falling through the cracks. Many of these children are referred for individualized staffings through the CASSP process.

- Case management has been expanded and utilized to help families and the system manage services for those children and families with the most complex, severe, and complicated service needs. Case managers are extremely important to the success of school-based and home-based services, especially in the most rural areas of the state.

- The Division of Behavioral Health Services has worked closely with the Arkansas Medicaid Division to look at potential modifications to the Arkansas Medicaid State Plan to improve availability and access to services.

- Several children's mental health bills were passed during the 2005 Legislative session that dealt with issues such as

    1. Continuity of mental health services for juveniles in their communities when possible in the least restrictive placement consistent with their needs.
    2. Revision of the CASSP law to include developing and implementing a comprehensive children's behavioral health system of care plan
    3. An Act to amend reporting on emotionally disturbed youth through the collection of much needed data that should enable the Legislature to have a clearer idea of the number of children being placed in residential placements, and the amount of Medicaid dollars being spent on children placed inside and outside the state of Arkansas.

The unmet service needs and critical gaps within the current system have been discussed and analyzed through data collection from the community mental health centers, Arkansas Medicaid, and the managed care company.

The following issues have been at the forefront of these discussions:

- Systemic problems with a lack of coordination and collaboration in regard to planning. There should be better coordination between mental health, children and family services, education, substance abuse, and juvenile justice to close some of the information and service gaps.
- A lack of qualified mental health professionals with expertise in children's mental health to meet the current need, especially in rural areas of the state, and especially minority providers.
- General access and availability issues, specifically in the most rural areas of the state.
- Need for a clear vision and mandate to develop an effective system of care for children's mental health services.
- Adequate resources including funding are needed for a comprehensive system of care
- Priority recognition of the need for wraparound and community-based services, and the cost savings involved (both human and financial) when these services are utilized prior to hospitalization.

In addition, the Arkansas Mental Health Planning Advisory Council gave recommendations for the FY06 Block Grant that included concerns about what is needed in the current system. Their concerns were:

- A lack of support services across the state for children and adolescents identified as SED or mentally ill and their families. This population does not usually fit into existing support services offered in the state.
- There are not enough beds across the state and no access in the rural areas.
- Increased hospitalizations for the U-21 population.
- How diversity issues are handled in our state-language and trauma issues.

III.a. PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM-ADULT PLAN

1) CURRENT ACTIVITIES

i. COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SYSTEM

OVERVIEW OF SERVICE SYSTEM PROVIDERS

The public community mental health system in Arkansas is a statewide system of services, with service sites in 69 of Arkansas' 75 counties. In addition to providing services at its own sites, CMHCs provide services off-site in clients' homes, schools, community hospitals, jails and client job sites. In this manner, services are provided in all 75 of the state's counties. Services are provided through 15 comprehensive Community Mental Health Centers (CMHCs), and three Community Mental Health Clinics serving clients with special needs. In SFY 2004, this public community mental health system served approximately 74,000 mental health clients of which approximately 50,000 were adults. All providers are private not-for-profit agencies that provide services funded primarily through Medicaid and contracts funded by state general revenue. All have national accreditation through either CARF or JCAHO.

Each CMHC provides the basic array of services described below to the residents of its geographic catchment area. The CMHCs serve as the single-point-of entry into the public mental health system, including as needed admission to the Arkansas State Hospital (ASH) and to local publicly financed acute inpatient care.

HEALTH, MENTAL HEALTH, REHABILITATION:

Upon entry into the system, the client is assessed by a mental health professional who determines appropriateness for mental health services and, if determined to be needed, develops a treatment plan in conjunction with the client. Each CMHC offers a full array of clinical mental health services and psychosocial rehabilitative services. Each CMHC also screens for physical health problems of each client and provides needed physical health care directly or refers for such care as needed.

Clinical mental health services include the following: diagnostic assessment and treatment planning, psychological testing, medication management, individual psychotherapy, group psychotherapy, marital/family therapy and acute day treatment**.**

Psychosocial Rehabilitative Services include the following: community support needs assessment and development of a plan of care, case management services including both on-site and off-site intervention, crisis intervention and crisis stabilization, psychosocial rehabilitative day services, collateral intervention involving consultation with other caregivers and persons involved in the clients life, and other rehabilitative and support services described below.

EMPLOYMENT SERVICES:

All CMHCs provide vocational screening as a routine part of the assessment of all clients. All CMHCs also refer to the state Vocational Rehabilitation Services and/or other employment service providers. Nine of the CMHCs are certified by Arkansas Rehabilitation Services as a vendor for providing supported employment services. However, the activity of some of these centers in actually providing this service is relatively low. This is an area in which DBHS hopes to increase activity. To this end, DBHS has participated with a local independent supported employment provider, the state's Developmental Disabilities Services and the state's Vocational Rehabilitation Services in providing grant-supported training in supported employment. Also, the DBHS has an interagency agreement with Arkansas Rehabilitation Services to promote supported employment services within the public mental health system by explicitly authorizing use of its funds to provide mental health support service to those who have received or are receiving supported employment services. A few CMHCs also provide in-house workcrew employment and sheltered workshop employment for clients.

HOUSING SERVICES:

The CMHCs offer housing supports ranging from unsupervised independent living to supervised living in group homes. Each CMHC designs its housing support to meet local needs. Support may include assistance with utility deposits to assistance with rent or purchasing basic necessities such as food or furniture. Several CMHCs have been very successful in obtaining Section 811 funds and/or rental vouchers. Five CMHCs are recipients of PATH grants.

EDUCATIONAL SERVICES

Many CMHCs offer general educational services such as GED or literacy classes on-site through arrangements with the Department of Education or through their own staff as part of psychosocial rehabilitative day programs. Other services are accessed through a referral to local community programs offered by vocational technical colleges or other educational institutions.

SUBSTANCE ABUSE SERVICES

As detailed below, the most frequent focus of substance abuse services by CMHCs is the provision of services for individuals with co-occurring mental health and substance abuse disorders. Additionally, eleven of the state's CMHCs are also licensed by the state's substance abuse treatment and prevention authority (ADAP) which itself was merged into DBHS as of July 1, 2003. These CMHCs provide an array of educational, outpatient treatment, residential treatment and detoxification substance abuse services. Those CMHCs that are not ADAP licensed providers refer to ADAP licensed providers in their community.

MEDICAL AND DENTAL SERVICES:

Medical services are provided both in-house by CMHC employed nurses and physicians and through referral to other community providers. In-house services focus particularly on ongoing monitoring of the physical health status of clients on psychotropic medications. A couple of

CMHCs are also providers of community (physical) health services and, as such, provide a very broad array of physical health services in-house to its clients. Dental health services (which are not covered under the state's Medicaid plan) are provided for through referral. For the large portion of CMHCs' clients with Medicaid, access to physical health care services is relatively easy. For persons without Medicaid or other third-party payment, access to these services is more difficult. To meet the physical health care needs of these individuals, case managers within the CMHCs have become very adept at locating physicians or dentists who will provide services free or at a reduced rate.

SUPPORT SERVICES

Obtaining needed support services, including income support and the housing support described above, is one of the primary responsibilities of a client's case manager. See immediately below for a description of case management.

DBHS also encourages peer support services through a grant to NAMI-Arkansas, which sponsors peer-run support groups for both consumers and family members**.** CMHCs refer clients to these support groups for services.

CASE MANAGEMENT SERVICES:

Case management is the heart of the Community Support Program (CSP) service system that assists persons with severe and persistent mental illness to maintain themselves in the community. For SFY 2005, the public mental health system budgeted for 656 case managers (102 mental health professionals and 554 mental health paraprofessionals) providing services to persons with a severe and persisting mental illness. The average caseload is approximately 38 clients per case manager. The DBHS requires that persons with a severe and persistent mental illness receive, on the average, a minimum of 2 fifteen-minute units of case management services per month. However, the data for SFY 2004 indicates that the system provided an average of 9 fifteen-minute units per month with more than 57% of those units delivered off-site from the CMHC.

Case management is defined as assisting the client in assessing needs, obtaining services, treatments and supports, and in preventing and managing crisis. Together with the client, the case manager plans, coordinates, monitors, adjusts, and advocates for services and supports to achieve the ultimate goal of independent community living.

SERVICES FOR PERSONS WITH CO-OCURRING MENTAL HEALTH /SUBSTANCE ABUSE) DISORDERS:

All CMHCs provide services to individuals with co-occurring mental illness and substance abuse disorders. The assessment of substance abuse issues is a routine part of the screening, comprehensive assessment and treatment planning for all mental health clients. The comprehensiveness and level of integration of treatment services for those with co-occurring

mental illness and substance abuse disorders varies among centers. A few centers with limited resources provide only limited in-house treatment with a focus on the substance abuse component of the client's presenting problems (typically including substance abuse issues as a part of individual therapy, group therapy and case management). These centers then refer out to and coordinate additional treatment with a substance abuse provider. Many centers provide a significant level of integrated in-house treatment of co-occurring mental illness and substance abuse disorders. Some integrated services are provided by staff that is dually certified as mental health professionals and substance abuse counselors. Other centers have staff that are certified substance abuse counselors, and coordinate treatment being provided by these counselors with that being provided by the mental health professional staff. Many mental health professional staff, although not formally certified as substance abuse counselors, have continuing professional education in this area. Integrated services include Mentally Ill Chemically Abusing (MICA) groups, in-house AA and NA groups, and education groups for at-risk populations. Several centers offer comprehensive programs addressing the needs of those with co-occurring mental illness and substance abuse disorders. In addition to those integrated services described, these centers provide such services as detoxification, inpatient and intensive residential treatment programs, multi-family groups, and chemical free-living environments. In addition to providing mental health services and integrated mental health/substance abuse services, as noted above, ten of the CMHCs either have contracts with or are certified by the Alcohol and Drug Abuse Prevention (ADAP) to provide services for persons with primary substance abuse disorders. As already noted, effective July 1, 2003 the state's substance abuse treatment authority agency (ADAP) was combined with the former DMHS to form the new Division of Behavioral Health Services. The integration of these two agencies at the state administrative level is now in process, and it is anticipated that the future will see a much higher level of integration of services at the provider/recipient level. As described above, implementation of a COSIG grant has been the primary vehicle through which initial steps are being taken to integrate the service delivery systems of these aspects of behavioral health care. The primary focus of the grant has been to implement system wide screening for co-occurring disorders with all mental health (MH) providers using a common instrument to screen for substance use disorders and all substance abuse (SA) treatment providers using a common instrument to screen for mental health disorders. The grant has supported planning and training activities attended by both mental health and substance abuse providers. There have been some reports of enhanced communication, referral and cooperation between SA and MH providers resulting from these joint activities. Plans are also underway to link the MH and SA data system (each using SSN as common unique identifiers) so as to be able to track client movement between the systems. Also, efforts are currently underway to add language to the Medicaid Provider's manual for the RSPMI program that clarifies that mental health treatment for those with co-occurring disorders will be paid for by Medicaid even though the state's Medicaid Plan does not cover treatment for substance use disorders themselves.

OTHER SERVICES LEADING TO REDUCTION OF HOSPITALIZATION:

The ASH aftercare program and the local acute care program are two other services that contribute significantly to the reduction of hospitalization. Additionally, there are three specialty

Mental Health Clinic programs focused on those with multiple previous hospitalization and high risk of rehospitalization.

The ASH aftercare program is a coordinated effort between the social work staff of ASH and the CMHCs. Prior to discharge of any patient from ASH, the social work department is in contact with a designated liaison at the CMHC in whose area the client will be residing post discharge. The ASH staff communicates the course of the client's treatment at ASH and coordinates the follow-up that will be needed. The CMHC is expected to provide an appointment for the client within two weeks of discharge from ASH. Coordinated and responsive follow-up leads to reduced risk of rehospitalization. As noted above, the newly initiated data system will track clients from treatment at ASH to community care which will allow tracking not just the number given appointments, but also the number of such appointments actually kept.

The local acute care program reduces hospitalization by providing for hospitalization in the client's community were coordination of care and follow-up is more easily accomplished than if the client is hospitalized at ASH. In one instance the coordination of care is to the extent of the psychiatric staff of the CMHC directly managing the client's inpatient treatment. The local acute care program began in November of 2003. Preliminary data on its operation during SFY 2005 indicates that lengths of stay will average about 5 days per episode, as compared to the 20+ day lengths of stay for an acute hospitalization at ASH. Some of this difference is possibly accounted for by a risk selection factor of who is referred to ASH rather than for local care, but likely some of the decrease in length of stay is the product of better coordination of care made possible with hospitalization in the client's own community. Also supportive of reduced hospitalization is the provision in the local acute care program that funds not expended to pay for inpatient care can be spent on providing services to reduce the need for inpatient care. CMHCs have used this provision to fund additional crisis stabilization programming and to purchase medications for those in acute crisis.

Specialized Community Mental Health Clinic programs are programs for persons with a severe and persistent mental illness who require a more intensive level of service intervention. The programs offer psychiatric services, case management, supervised community housing, day treatment, job coaching, medication monitoring, transportation, assistance with finances, assistance with daily living skills, and 24 -hour crisis intervention and emergency services. All specialized community programs are either CARF or JCAHO accredited. Specialized community programs include:

Birch Tree Communities: Birch Tree Communities is a community-based residential program that offers specialized services to persons with a severe and persistent mental illness. Originally based on the Benton Services Center campus, the program has now expanded to a large portion of the state, with nine different service sites. Birch Tree has been instrumental in creating a community living environment for persons with mental illnesses that have in the past been very difficult to maintain in the community. Birch Tree served 290 persons in SFY 2004.

Small Group Work Therapy: Small Group Work Therapy has been in operation since 1964 and is based on the Fairweather model of group living and group decision-making. In SFY 2004 SGWT served 143 individuals. Also in SFY 2003, SGWT added Assertive Community

Treatment as a service component.

GAIN Program: The GAIN program (Greater Assistance for Those in Need) is an assertive community treatment program located in Little Rock. In SFY 2004 GAIN served 182 individuals. The program places special emphasis on serving clients with multiple inpatient admissions or those for whom traditional services have not been adequate.

In addition to the above three specialty programs, DBHS contracts with Liberty Healthcare to operate a secure residential program for persons who have been found not guilty by reason of mental disease or defect and who also have a substance abuse disorder. Upon discharge from the residential program, clients are followed in an Assertive Community Treatment Program operated by Liberty Healthcare in cooperation with a local CMHC.

Closely related to efforts to reduce psychiatric hospitalization are efforts to reduce unnecessary nursing home placement of individuals with mental illness. Arkansas maintains a very active Preadmission Screening Resident Review (PASRR) program for Medicaid recipients seeking admission to a nursing home or presenting a mental status change while residing in a nursing home. A DBHS employee devotes approximately fifty percent of her time to doing level two PASRR reviews. In Calendar 2004, this staff member conducted 519 reviews, which compares to 416 reviews conducted in calendar 2003. In addition to determining the appropriateness of nursing home placement, the review determines if the individual needs any mental health services, either in the nursing home or in order to be able to be maintained in a less restrictive community setting. Individuals are referred to their local CMHC for any mental health services that are determined to be needed.

ii. MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY

Arkansas' total population is 2.7+ million of which 25% are children under the age of eighteen. The 2000 census data shows that 80% of the population is white; 15.7% is black or African American; less than 1% is American Indian and Alaska Native; Asian; Native Hawaiian and Other Pacific Islander, and; 3.2% is Hispanic or Latino. Over the last eleven years, Arkansas' Hispanic population has significantly increased. In 1990, the state total was 19,876 and in 2000, the total was 86,866—an increase of 66,990. U. S. Census figures indicate Arkansas' population is divided between 49% urban and 51% rural residents. There are 75 counties in the state—12 of which would be considered urban and 63 considered rural. The per capita income was reported to be $19,595 in the 2000 census. Arkansas uses the latest (2004) federal prevalence estimate of serious mental illness of 111,823.

As described above, the state of Arkansas uses the federal definition to identify persons with a serious mental illness. In SFY 2004, the public mental health system provided services to approximately 74,000 mental health clients of whom 49,800 were adults. Approximately 25,800 of these adult persons served are identified as having a serious mental illness. Of this 25,800 approximately 13,300 are identified as needing case management and other community support services. This later group generally meets the federal definition for severe and persistent mental illness (SPMI).

iii. NOT APPLICABLE TO ADULT PLAN

iv. TARGET SERVICES TO RURAL AND HOMELESS POPULATIONS

SERVICES TO HOMELESS POPULATION

The current estimate of homeless SMI adults with a serious mental illness in Arkansas is 2,981. The 2000 census reports a total state population of 2,673,400. Of this number, 17.5 %, or 467,845, are reported to live below the federal poverty level. Children are reported to represent 25.4% of the total population (679,044), and 25% of these children (169,761) are reported to live below the federal poverty level. The number of adults living below the poverty level is calculated to be 298,084 (467,845 – 169,761). It is estimated that 2% of the adults living in poverty, or 5,962, are homeless. It is estimated that 50% of these homeless adults, or 2,981, have a Serious Mental Illness.

All CMHCs provide services to the homeless. A person's housing status is routinely assessed at time of admission. However, several, especially those without a PATH grant, report difficulty in tracking services to this population. The major initiative for providing mental health services to homeless persons is through the CMHCs receiving a PATH Grant. The DBHS issues a request for proposals to providers of public mental health services to fund services specifically for persons who are suffering from serious mental illness or serious mental illness and substance abuse and are homeless or at-risk of becoming homeless. The PATH Grant ($300,000) funded five programs in SFY 2005. These programs use assertive outreach to homeless individuals by seeking them out in the places where they tend to gather. Once identified, needed services can be provided at a location where the person feels comfortable and safe. PATH Grant recipients collaborate with other service agencies to coordinate services and facilitate outreach. For the most recent grant year reporting cycle (9/1/03 – 8/31/04), 816 adults with a serious mental illness were provided services through a PATH grant.

At the DBHS level, a staff person is a member of the Interagency Council on Homelessness, participates in the Community Homeless Assessment Local Education Networking Group (CHALENG), a Veterans Administration committee coordinating services among homeless providers, and participates in the consolidated plan and continuum of care planning activities.

SERVICES TO INDIVIDUALS IN RURAL AREAS

Although becoming somewhat more urbanized, Arkansas continues to have a significant rural population. Based on the United States census definition of Standard Metropolitan Statistical Areas, Arkansas has 12 counties that are considered urban and 63 that are considered rural. According to the 2000 census, the 63 counties considered rural are home to 51% of the adult (18 years of age and older) population. Data for SFY 2004 indicates that 61% of the adult SMI population served resided in the 63 rural counties, indicating good access for rural residents.

As previously noted, CMHCs have service sites in 69 of the states 75 counties and deliver services in all 75 counties. To further increase access by those in rural areas, many CMHCs run fleets of vans to pick up those clients needing services and many case managers transport clients in their private automobiles. For SFY 2005, CMHCs projected that they would operate 250 vehicles (with a total seating capacity of 2,917) to provide client transportation. CMHCs projected that these vehicles would travel a total of 3,339,570 miles during the year.

v. MANAGEMENT SYSTEMS

Financial Resources

DBHS controlled funds budgeted for SFY 6 are shown in TABLE 1 below.

TABLE l. SFY 2006 DBHS CONTROLLED FINANCIAL RESOURCES

COMMUNITY PROGRAM FUNDING	
CMHCs grants for basic services to priority populations	7,409,209
CMHCs per capita grants for basic program operations	8,780,603
CMHCs grants for alternative to ASH utilization	2,653,236
CMHCs grants for local acute care-continuing	5,800,000
CMHC grants for local acute care-new	5,750,000
CMHCs grants for CASSP activities	1,240,000
CMHC federal block grant allocation	3,355,812
CMHC PATH grants	300,000
Outpatient Forensic Evaluations-fee for service	410,000
APP-Residential & ACT for co-occurring disorders for NGRI population	1,657,250
GAIN for Assertive Community Treatment (ACT)	981,120
Community Program Subtotal	**38,337,230**
NON-COMMUNITY PROGRAM FUNDING	
Arkansas Research and Training Institute	1,285,844
Arkansas State Hospital	23,354,991
Arkansas Health Center Skilled Nursing Facility	6,951,392
Non-Community Subtotal	**31,592,227**
GRAND TOTAL	**69,929,457**
Community Program Funding as Percent of Total Funding	**55%**

The total budget for mental health controlled by DBHS is approximately $70 million per year. DBHS-controlled funds budgeted for community-based programs for SFY 06 total $38,337,230 or approximately 55% of the DBHS budget. However, budgeted funds are subject to being reduced if the state experiences a revenue shortfall, as occurred in SFY 2003. Note that DBHS has made significant changes in the methodology for computing DBHS-Controlled Financial

Resources. Medicaid funds, which are not controlled by DBHS, have been excluded in the calculation of both Community and Non-Community program budgets. In past years, the totals for Community Programs did not include Medicaid funding, which is not under the control of DBHS. However, Medicaid funds were included in the calculation of Non-Community Program Funding, even though these Medicaid funds are also not controlled by DBHS. The new methodology more accurately reflects DBHS' actual control of funds and its allocation priorities.

The public mental health system in Arkansas relies heavily on Medicaid funding. In SFY 04, the Community Mental Health Centers and Clinics received approximately $100 million in reimbursements under the Medicaid rehab option. The total budgets for Community Mental Health Centers and Clinics for SFY 2004 was approximately $174 million.

Specific to this application, Block Grant funds are allocated on a per capita basis to fifteen CMHCs to support services to targeted clients as mandated by the law. In addition to funding services through the community mental health centers, the Block Grant is used to support some administrative and training activities. The details of the allocation of these Block Grant funds are shown in TABLE 2. below.

TABLE 2. SFY 2006 FEDERAL BLOCK GRANT ALLOCATIONS

COMMUNITY MENTAL HEALTH CENTERS	SMI Adult	SED Child	Total
Community Counseling Services	$144,365.98	$78,414.03	$222,780.01
Counseling Associates	$183,361.31	$117,951.16	$301,312.47
Counseling Clinic	$71,296.55	$45,756.75	$117,053.30
Counseling Services of Eastern Arkansas	$120,122.89	$94,872.77	$214,995.66
Delta Counseling Associates	$71,459.17	$48,593.43	$120,052.60
Little Rock Community Mental Health Center	$154,762.75	$98,079.36	$252,842.11
Mid-South Health System	$213,631.96	$137,889.63	$351,521.59
Health Resources of Arkansas	$195,664.96	$110,666.98	$306,331.94
Ozark Counseling services	$94,316.50	$49,442.92	$143,759.42
Ozark Guidance Center	$298,355.67	$194,008.10	$492,363.77
Professional Counseling Associates	$206,179.69	$135,655.12	$341,834.81
South Arkansas Regional Health Center	$106,386.51	$68,903.95	$175,290.46
Southeast Arkansas Behavioral Healthcare Systems	$123,137.24	$79,650.63	$202,787.87
Southwest Arkansas Counseling and Guidance Center	$97,581.66	$66,820.00	$164,401.66
Western Arkansas Counseling and Guidance Center	$201,937.60	$135,515.38	$338,452.98
CMHC Subtotal	$2,282,560.44	$1,463,220.21	$3,745,780.65
ADMINISTRATION			$102,146.35
GRANT TO AR. COUNCIL OF CMHC's			$10,000.00
GRANT TO NAMI-ARKANSAS			$85,000.00
TOTAL			$3,942,927.00

Staffing Resources

For SFY 2005, the community-based public mental health system employs approximately 2,900 staff. All staff providing direct services through the community system are either licensed or certified by the State. All CMHCs have psychiatrists, with support from psychologists, social

workers, licensed professional counselors, registered nurses, licensed psychiatric nurses, case managers, and various administrative staff. The CMHC system offers approximately 65 internships in various disciplines including psychology, social work, and nursing. Recruiting and retaining mental health professionals is always challenging and the challenge has recently taken on increasing proportions. Psychiatrists are always in short supply and locating those willing to work in rural areas is difficult. For SFY 2005, there are a total of 59.2 FTE psychiatrists, 50.6 FTE doctoral psychologists, and 750.3 FTE mental health professionals of all type (doctoral and masters level) employed by the CMHCs.

Training of Service Providers

The DBHS makes significant efforts to provide training opportunities for the mental health system. The state hospital is certified as an intern training site for three psychologists pursuing a doctoral degree, and also serves as an intern site for second year social workers. The psychiatry residents at the University of Arkansas Medical Sciences Campus rotate through the inpatient units at the state hospital, and at various community-based sites in the public mental health system. The DBHS sponsors yearly training related to conducting both children and adult forensic evaluations.

Through the Arkansas Research and Training Institute (RTI), DBHS collaborates with community providers and various training schools to promote the use of state-of-the-art practices. The Institute has consultation teams available to assist providers with innovative treatment approaches particularly in the area of services for persons with a mental illness and a substance abuse disorder. RTI also has been awarded a grant to undertake planning for implementation of best practices in the area of medication management.

In addition to the DBHS-sponsored activities, the CMHCs provide regular in-service training to staff and other providers to keep them informed of current mental health practices and policies. Participants include clinical providers, law enforcement personnel, local hospital staff, emergency room staff, and others who may come into frequent contact with persons with mental illness. The Council of CMHCs, with support from DBHS, sponsors an annual four-day Behavioral Health Institute that provides extensive training opportunities to over 1,000 attendees, including staff of CMHCs, clients, family members and advocates.

Training of Emergency Health Services Providers Regarding Mental Health

Staff from the Division of Behavioral Health Services (DBHS) provides training at the Law Enforcement Training Academy for persons seeking to become certified law enforcement officers. As part of a SAMHSA grant, DBHS and a partner CMHC provide training to Little Rock, Arkansas police officers on crisis management. Through the local acute care programs, CMHCs have regular, frequent and on-going contact with staff of hospital emergency rooms that includes educating these staff regarding appropriate referrals to the public mental health system and the procedures for making these referrals.

2) GOALS, TARGET AND ACTION PLANS

The Performance Indicator Descriptions and the Performance Indicator Table for the Goals listed for the four criteria areas below appear at the end of this section. As described above, for SFY 2006, which will serve as the reporting period for this plan, DBHS is initiating a new, much enhanced client and services data system and a statewide uniform consumer satisfaction survey. For this reason, in several of the goal areas below, DBHS will be collecting and establishing baseline performance data rather than setting a numeric target as had been set in previous year plans. The specifics of each baseline data collection will be detailed below.

i. COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SYSTEM

DBHS plans to maintain a basic comprehensive community-based adult mental health system of care that minimizes inpatient hospital stays (including, in particular, readmissions to ASH) and that delivers services to clients that are viewed by the clients as being accessible and effective. DBHS plans to move the system of care towards the delivery of care using evidenced-based practices, in particular, increasing the numbers of those receiving Assertive Community Treatment. DBHS will also make a determination of the level of availability of other evidenced-based practices and develop data system capability to reliably measure the numbers of clients receiving these services.

Inpatient stays will be minimized by providing timely aftercare to those leaving the Arkansas State Hospital and by providing responsive on-going case management to those clients most at-risk for hospitalization. It is noted that the goal regarding timely aftercare appointments set here refers to timeliness of appointments made. The current data system does not allow DBHS to collect data on the percentage of these appointments actually kept. However, the new data system referenced above links data from both ASH and the CMHCs which will allow such data to be collected. DBHS anticipates being able to set goals related to percent of aftercare appointments actually kept in future year plans. Case management services are made available to those assessed most at-risk of hospitalization and in need of this and other community support services. These services are delivered both at the CMHCs facility sites and off-site in the community, including at the client's home. Responsiveness of case management services will be assessed in terms of the percentage of case management service units provided off-site as compared to those delivered on-site.

GOAL i. A. Eighty-percent of adults being discharged from the Arkansas State Hospital will have an aftercare appointment scheduled within 14 days of date of discharge.

GOAL i. B. At least 50% of units of case management will be delivered off-site from the facilities of the community provider.

The effectiveness of the above two strategies will, in part, be measured by the rate of readmissions to the Arkansas State Hospital.

GOAL i. C. Fewer than 10% of adult patients discharged from the Arkansas State Hospital will be readmitted within 30 days of discharge.

GOAL i. D. Fewer than 25% of adult patients discharged from the Arkansas State Hospital will be readmitted within 180 days of discharge.

Client satisfaction with the system of care will be monitored. As described in previous plans, until this year, each provider was conducting surveys and reporting results to DBHS. Providers used different survey instruments and different items to measure satisfaction with access and outcomes of care. In most instances, providers used convenience rather than random samples. With its data infrastructure grant, DBHS is in the process of implementing a standardized statewide consumer satisfaction survey using the standard MHSIP Adult survey. Results from this new, much improved survey methodology will be used to establish baseline performance to serve as the basis for setting targets for future year plans.

GOAL i. E. Data on client rating of satisfaction with access to care will be collected from a random sample of at least 400 consumers using a statewide uniform survey methodology. Data from this survey will be used to establish a performance baseline.

GOAL i. F. Data on client rating of satisfaction with outcomes of care will be collected from a random sample of at least 400 consumers using a statewide uniform survey methodology. Data from this survey will be used to establish a performance baseline.

DBHS provided the funding to start up the state's first Assertive Community Treatment evidenced based program. DBHS continues to provide some of the financial support for this program and is increasing its funding to this program for SFY 2006, primarily to offset increased costs. DBHS has provided some technical support to the development of the state's other three ACT programs, one of which started up this past year. DBHS funds also support part of the operation of this newest ACT program. DBHS' goal is to support the continued increased availability of ACT.

GOAL i. G. The number of adults receiving the EBP of Assertive Community Treatment will be increased by 5%.

DBHS is in the process of conducting a survey to determine the extent to which other EBPs are available within the state public mental health system. Challenages in conducting this survey, in particular definitional issues, have been noted above. Also as noted above, DBHS is in the process of developing enhancements to its new data system that will allow systematic reporting of the number of clients receiving these EBPs. The primary challenge in this regard is that EBPs are not tied to unique specific billing codes. DBHS does anticipate being able, in the future, to establish baseline performance levels for the provision of EBPs in addition to ACT, and being then able to establish targets for improving the availability to these EBPs.

ii. MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY

DBHS will continue to monitor the penetration of the public mental health system in terms of providing services to its target population of adults with a serious mental illness. As described above, the new enhanced data system will, for the first time, have system wide unique client

identifiers that will allow the determination of the unduplicated numbers of clients served. The amount of duplication in the previous counts reported is unknown and, for this reason, the goal for this plan is to establish a baseline of unduplicated served.

GOAL ii. A. The public mental health system will determine the unduplicated number of clients with a serous mental illness served in the state's public mental health system to establish a baseline of service penetration rate based on this unduplicated count.

As noted in last year's plan, currently services of the public mental health system are not restricted to those who are seriously mentally ill, but may be provided to others with mental health problems to the extent resources are available after services have been provided to the priority seriously mentally ill population. Also, as noted before, for reasons of cost containment and concerns regarding appropriate utilization, DBHS anticipates being in discussion with the state's Medicaid authority regarding defining a narrower class of eligibles, at least for certain services, than is defined by the federal definitions of SMI and SED. This discussion is ongoing.

At the request of SAMHSA, DBHS initiated contact with the state's Health Department and requested that it include in its next Behavioral Risk Factor Surveillance System (BRFSS) the optional module PHQ 8 (a measure of the prevalence of anxiety and depression. The Health Department has included this module in its preliminary draft of the survey. The final survey content will not be set until the fall of 2005. However, DBHS has every reason to believe that this module will be included in the survey when it is conducted in 2006. DBHS anticipates being able to use information from this survey to begin assessing the extent of unmet need.

iii. NOT APPLICABLE TO THE ADULT PLAN

iv. TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS

Arkansas' public community mental health system was largely developed to serve a rural population and continues to have a significant focus on serving this population. Although there has been some urbanization of the state, over half of the state is still considered to be rural as defined by residing in a county that is not part of a Metropolitan Statistical Area. DBHS plans to continue its emphasis on services in rural areas including the wide dispersal of service sites, the provision of off-site services and the provision of extensive transportation services.

GOAL iv. A. As a percentage of the population of the county in which they reside, the number of adults with a serious mental illness served in rural counties will at least equal that for urban counties. In effect this means that the service penetration rate in rural counties will at least equal that in urban counties.

All of Arkansas' CMHCs provide services to the homeless. These services are, in particular, supported by PATH grant funding. Arkansas plans to continue its method of distributing PATH funds through a competitive RFP process that includes demonstration of need. This method helps focus the additional support of PATH funding in the areas of most need. Housing status,

including homelessness, is one of the fields in DBHS' new enhanced data system. Thus, for the first time DBHS will be able to determine unduplicated counts of homeless clients served. The amount of duplication in the previous counts reported is unknown and, for this reason, the goal for this plan is to establish a baseline of unduplicated homeless served.

GOAL iv. B. The public mental health system will determine the unduplicated number of homeless clients served in the state's public mental health system to establish a baseline of the number of homeless served.

v. MANAGEMENT SYSTEMS

As noted above, DBHS has made significant changes in the methodology for computing DBHS-Controlled Financial Resources. Medicaid funds, which are not controlled by DBHS, have been excluded in the calculation of both Community and Non-Community program budgets. In past years, the totals for Community Programs did not include Medicaid funding, which is not under the control of DBHS. However, Medicaid funds were included in the calculation of Non-Community Program Funding, even though these Medicaid funds are also not controlled by DBHS. The new methodology more accurately reflects DBHS' actual control of funds and its allocation priorities.

GOAL v. A. At least fifty percent of the funds under DBHS' control will be devoted to community-based programming.

Performance Indicator Description

Goal i. A. All persons being discharged from the Arkansas State Hospital will have timely access to aftercare services.

Target: 80% percent of adults being discharged from the Arkansas State Hospital will have an aftercare appointment scheduled within 14 days of date of discharge.

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Population: Adults being discharged from the Arkansas State Hospital.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Aftercare Appointments.

Indicator: Percentage of adults discharged from the Arkansas State Hospital who have an aftercare appointment scheduled within fourteen days of date of discharge.

Measure: Numerator: Number of adults discharged from the Arkansas State Hospital who have an aftercare appointment scheduled within fourteen days of date of discharge.

Denominator: Number of adults discharged from the Arkansas State Hospital.

Sources(s) of Information: Arkansas State Hospital Social Work Department database report.

Special Issues: None.

Significance: Prompt aftercare reduces risk of rehospitalization and promotes community tenure.

Performance Indicator Description

Goal i. B. Provide case management services in an assertively responsive manner.

Target: At least 50% of units of case management will be delivered off-site from the facilities of the community provider.

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Population: Adults with a serious mental illness receiving case management services.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Off-site Case Management.

Indicator: Percentage of all units of case-management that are delivered off-site from the facilities of the community provider.

Measure: Numerator: Number of 15 minute units of case management delivered off-site.

Denominator: Number of 15 minute units of case management delivered both off-site and on-site.

Sources(s) of Information: DBHS Enhanced Data Reporting System.

Special Issues: None.

Significance: Providing services off-site make them more accessible to clients and support community integration.

Performance Indicator Description

Goal i. C. Short-term readmission to the Arkansas State Hospital will be reduced to the extent possible.

Target: Fewer than 10% of adult patients discharged from the Arkansas State Hospital will be readmitted within 30 days of discharge.

Population: Adults discharged from the Arkansas State Hospital.

Criterion: Comprehensive, community-based mental health system.

Brief Name: 30-Day Readmission Rate.

Indicator: Percentage of adults readmitted within 30 days of discharge from the Arkansas State Hospital.

Measure: Numerator: Number of discharges of adults followed by readmission within 30 days of the discharge.

Denominator: Number of discharges of adults from the Arkansas State Hospital.

Sources(s) of Information: Arkansas State Hospital Data System.

Special Issues: In order to be able to report 180 day readmissions, and for the 30-day and 180-day readmissions to be based on the same discharge population, the reporting time period for this indicator target will be the most recent calendar year (calendar 2005) rather than the most recent state fiscal year (2006) which serves as the time period for other indicator targets in this plan. Discharges include those discharged to another facility for acute medical care. System changes are being undertaken to allow these discharges for acute medical care to be excluded in future years.

Significance: A hallmark of an adequate aftercare with comprehensive community-based services is the ability to avert rehospitalization within a brief period following discharge.

Performance Indicator Description

Goal i. D. Intermediate term readmission to the Arkansas State Hospital will be reduced to the extent possible.

Target: Fewer than 25% of adult patients discharged from the Arkansas State Hospital will be readmitted within 180 days of discharge.

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Population: Adults discharged from the Arkansas State Hospital.

Criterion: Comprehensive, community-based mental health system.

Brief Name: 180-Day Readmission Rate.

Indicator: Percentage of discharges of adults followed by a readmission within 180 days of discharge from the Arkansas State Hospital.

Measure: Numerator: Number of discharges of adults followed by readmission within 180 days of the discharge.

Denominator: Number of discharges of adults from the Arkansas State Hospital.

Sources(s) of Information: Arkansas State Hospital Data System.

Special Issues: In order to be able to report 180-day readmissions, and for the 30-day and 180-day readmissions to be based on the same discharge population, the reporting time period for this indicator target will be the most recent calendar year (calendar 2005) rather than the most recent state fiscal year (2006) which serves as the time period for other indicator targets in this plan. Discharges include those discharged to another facility for acute medical care. System changes are being undertaken to allow these discharges for acute medical care to be excluded in future years.

Significance: A hallmark of an adequate aftercare with comprehensive community-based services is the ability to avert rehospitalization within an intermediate time period following discharge.

Performance Indicator Description

Goal i. E. Maintain a high level of satisfaction with access to service by adults receiving services from the public mental health system.

Target: Data on client rating of satisfaction with access to care will be collected from a random sample of consumers using a statewide uniform survey methodology. Data from this survey will be used to establish a baseline performance.

Population: Sample of adults receiving public mental health services.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Client Satisfaction with Access.

Indicator: Percentage of adults sampled that express positive satisfaction with access to services.

Measure: Numerator: The number of adults surveyed who rated access to care positively.

Denominator: Number of adults surveyed who responded to survey items regarding satisfaction with access.

Sources(s) of Information: State-wide, random sample, uniform consumer satisfaction survey.

Special Issues: In previous years this data was based on aggregated data from provider administered surveys, which varied in specific content among providers. For this year, a statewide uniform MHSIP adult survey will be administered to a random sample of adult consumers. Based on this methodology, baseline performance will be established.

Significance: Persons satisfied with access to care are more likely to follow through with receiving needed services.

Performance Indicator Description

Goal i. F. Maintain a high level of satisfaction with outcomes of service by adults receiving services of the public mental health system.

Target: Data on client rating of satisfaction with outcomes of care will be collected from a random sample of consumers using a statewide uniform survey methodology. Data from this survey will be used to establish a baseline performance.

Population: Sample of adults receiving public mental health services.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Client Satisfaction with Outcomes.

Indicator: Percentage of adults sampled that express positive satisfaction with outcomes of care.

Measure: Numerator: The number of adults surveyed who rated outcomes of care positively.

Denominator: Number of adults surveyed who responded to survey items regarding satisfaction with outcomes.

Sources(s) of Information: Statewide, random sample, uniform consumer satisfaction survey.

Special Issues: In previous years, this data was based on aggregated data from provider administered surveys, which vary in specific content among providers. For this year, a statewide uniform MHSIP adult survey will be administered to a random sample of adult consumers. Based on this methodology baseline performance will be established.

Significance: Persons satisfied with outcomes of care are more likely to follow through with receiving needed services. Achieving consumer-valued outcomes is the ultimate objective of a community-based system of care.

Performance Indicator Description

Goal i. G. All adult clients needing Assertive Community Treatment (ACT) will receive this service.

Target: The number of adults receiving the EBP of Assertive Community Treatment will be increased by 5%.

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Population: SMI adults receiving ACT.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Evidenced-Based Treatment: Assertive Community Treatment.

Indicator: Percent increase in clients receiving ACT.

Measure: Numerator: The number of adults that received ACT in SFY 2006 minus the number that received the service in SFY 2005.

Denominator: Number of adults that received ACT in SFY 2005.

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Sources(s) of Information: Ad Hoc provider reports.

Special Issues: None.

Significance: Assertive Community Treatment is an evidenced-based treatment with proven efficacy in reducing rehospitalization in those at significant risk and in improving their community functioning.

Performance Indicator Description

Goal ii. A. Maintain or expand access to mental health services for the population of adults with serious mental illness.

Target: The public mental health system will determine the unduplicated number of adults with a serious mental illness served in the state's public mental health system to establish a baseline service penetration rate based on this unduplicated count.

Population: Adults with a serious mental illness receiving services in the public mental health system.

Criterion: Prevalence and treated prevalence of mental illness.

Brief Name: Treated prevalence of serious mental illness.

Indicator: Percent of adults estimated to have a serious mental illness that receive treatment in the public mental health system.

Measure: Numerator: Number of adults with a serious mental illness that received services in the public mental health system.

Denominator: Estimated prevalence of adults with a serious mental illness.

Sources(s) of Information: DBHS' Enhanced Data Reporting System, CMHS supplied prevalence estimate.

Special Issues: In previous years, this data was based on reporting that did not have unique client identifiers, so it was not possible to calculate unduplicated counts of those served. The new enhanced data system will, for the first time, have system wide unique client identifiers that will allow the determination of the unduplicated numbers of clients served. The amount of duplication in the previous counts reported is unknown, and for this reason, the goal for this plan is to establish a performance baseline.

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Significance: Setting quantitative goals for the number of adults with a serious mental illness to be served in the public mental health system is a key requirement for the mental health block grant legislation. Quantitative goals in this area also serve as a benchmark for assess to the system.

Performance Indicator Description

Goal iv. A. Maintain or expand access to mental health services for the population of adults with serious mental illness that reside in rural areas.

Target: As a percentage of the population of the county in which they reside, the number of adults with a serious mental illness served in rural counties will at least equal that for urban counties. In effect this means that the service penetration rate in rural counties will at least equal that in urban counties.

Population: Adults with a serious mental illness.

Criterion: Targeted Services to Rural and Homeless Populations.

Brief Name: Services to rural population.

Indicator: Percent of treated adults with a serious mental illness residing in rural counties as compared to percent of treated adults with a serious mental illness residing in urban counties.

Measure: Numerator: Percent of treated adults with a serious mental illness residing in rural counties.

Denominator: Percent of treated adults with a serious mental illness residing in urban counties.

Sources(s) of Information: DBHS' Enhanced Data Reporting System.

Special Issues: Urban counties are those that are part of a Metropolitan Statistical Area. There are currently twelve such counties in Arkansas.

Significance: More than half of Arkansas' population reside in rural areas and it is important to continue to assure access to services to this population.

Performance Indicator Description

Goal iv. B. Persons who are homeless and have a serious mental illness will have access to public mental health services.

Target: The public mental health system will determine the unduplicated number of homeless clients served in the state's public mental health system to establish a baseline of the number of homeless served.

Population: Adults with a serious mental illness who are homeless.

Criterion: Targeted Services to Rural and Homeless Populations.

Brief Name: Services to homeless.

Indicator: Percentage of homeless adults with a serious mental illness receiving public mental health services.

Measure: Numerator: The number of homeless persons with a serious mental illness who receive public mental health services.

Denominator: The estimated number of homeless persons with serious mental illness.

Sources(s) of Information: DBHS' Enhanced Data Reporting System.

Special Issues: In previous years, this data was based on reporting that did not have unique client identifiers, so it was not possible to calculate unduplicated counts of those served. The new enhanced data system will, for the first time, have system-wide unique client identifiers that will allow the determination of the unduplicated numbers of clients served. The amount of duplication in the previous counts reported is unknown and for this reason the goal for this plan is to establish a performance baseline.

Significance: The homeless are an especially vulnerable and hard to reach population, and require special effort to assure access to services. The seriously mentally ill are at significant risk for homelessness.

Performance Indicator Description

Goal v. A. Maintain or increase the percentage of State Mental Health Authority (SMHA) controlled funds available to community-based programs.

Target: At least fifty percent of the funds under DBHS' control will be devoted to community- based programming.

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Population: Persons receiving public mental health services.

Criterion: Management systems.

Brief Name: Community-based funding.

Indicator: Percentage of SMHA-controlled funds available to community-based programs.

Measure: Numerator: The total SMHA-controlled funds available to community-based programs.

Denominator: Total SMHA controlled funds.

Sources(s) of Information: SMHA management data system.

Special Issues: Note that DBHS has made significant changes in the methodology for computing DBHS-Controlled Financial Resources. Medicaid funds, which are not controlled by DBHS, have been excluded in the calculation of both Community and Non-Community program budgets. In past years, the totals for Community Programs did not include Medicaid funding, which is not under the control of DBHS. However, Medicaid funds were included in the calculation of Non-Community Program Funding, even though these Medicaid funds are also not controlled by DBHS. The new methodology more accurately reflects DBHS' actual control of funds and its allocation priorities.

Significance: This percentage is a measure of the commitment of the SMHA to supporting and strengthening a community-based system of care.

Performance Indicator Table for State Plan-Adults

Name of Performance Indicator: i. A. Aftercare Appointments
Population: Adults Discharged From ASH
Criterion: Comprehensive Community-Based Mental Health Service System.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	90%	92%	80%	80%	
Numerator	642	611	640	640	
Denominator	714	663	800	800	

Name of Performance Indicator: i. B. Off-Site Case Management
Population: Adults with SMI Receiving CSP Services
Criterion: Comprehensive Community-Based Mental Health Service System.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	58%	56%	50%	50%	
Numerator	796,463	746,439	733,000	733,000	
Denominator	1,383,958	1,316,628	1,466,000	1,466,000	

Name of Performance Indicator: i. C. 30-Day Readmission Rate
Population: Adults Discharged From ASH
Criterion: Comprehensive Community-Based Mental Health Service System.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	7.9%	5.1%	10%	10%	
Numerator	79	49	98	98	
Denominator	997	954	975	975	

Name of Performance Indicator: i. D. 180-Day Readmission Rate
Population: Adults Discharged From ASH
Criterion: Comprehensive Community-Based Mental Health Service System..

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	20.1%	17.0%	25%	25%	
Numerator	200	162	244	244	
Denominator	997	954	975	975	

Name of Performance Indicator: i. E. Consumer Satisfaction With Access
Population: Adult Clients of the public mental health system
Criterion: Comprehensive Community-Based Mental Health Service System.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	91%	89%	80%	Establish Baseline	
Numerator	2,986	3,010	2,080	New	
Denominator	3,283	3,371	2,600	Measure	

Name of Performance Indicator: i. F. Consumer Satisfaction With Outcomes
Population: Adult Clients of the public mental health system
Criterion: Comprehensive Community-Based Mental Health Service System.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	88%	90%	80%	Establish Baseline	
Numerator	2,893	3,207	2,080	New	
Denominator	3,290	3,581	2,600	Measure	

Name of Performance Indicator: i. G. EBP - Assertive Community Treatment
Population: Adults receiving ACT
Criterion: Comprehensive Community-Based Mental Health Service System.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator			Establish Baseline	5%	
Numerator			New	15	
Denominator			Measure	300	

Name of Performance Indicator: ii. A. Treated Prevalence
Population: Adults with a serious mental illness
Criterion: Mental Health System Data Epidemiology.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	28%	24%	20%	Establish Baseline	
Numerator	26,076	25,837	22,072	New	
Denominator	93,398	107,304	110,360	Measure	

Name of Performance Indicator: iv. A. Services To Rural Population
Population: Residents Of Rural Counties
Criterion: Targeted Services to Rural and Homeless Population.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	1.1%	1.5%	1.0%	1.0%	
Numerator	1.37	1.54	1.30	1.30	
Denominator	1.24	1.04	1.30	1.30	

Name of Performance Indicator: iv. B. Services To Homeless
Population: Homeless adults with a serious mental illness
Criterion: Targeted Services to Rural and Homeless Population.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	54%	35%	35%	Establish Baseline	
Numerator	1,605	1,258	1,043	New	
Denominator	2,981	2,981	2,981	Measure	

Name of Performance Indicator: v. A. Community Services Funding
Population:
Criterion: Management System.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006* Target	FY 2007 Target
Performance Indicator	37%	37%	40%	50%	
Numerator	29.6(m)	32.0(m)	37.2(m)	35.0(m)	
Denominator	80.0(m)	87.0(m)	93.0(m)	70.0(m)	

*FY 2006 will use new methodology for computing DBHS' Controlled Funds. See text for detailed explanation.

III.b. PERFORMANCE GOALS AND ACTION PLANS TO IMPROVE THE SERVICE SYSTEM-CHILDREN'S PLAN

1) CURRENT ACTIVITIES

i. COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SYSTEM

OVERVIEW OF SERVICE SYSTEM PROVIDERS

The public community mental health system in Arkansas is a statewide system of services, with service sites in 69 of Arkansas' 75 counties. In addition to providing services at its own sites, CMHCs provide services off-site in clients' homes, schools, community hospitals, jails and client job sites. In this manner, services are provided in all 75 of the state's counties. Services are provided through 15 comprehensive Community Mental Health Centers (CMHCs). In SFY 2004, the public community mental health system served approximately 74,000 mental health clients of which approximately 25,000 were children (some counted in both categories when they turn 18 during the year. All providers are private, not-for-profit agencies that provide services funded primarily through Medicaid and contracts funded by state general revenue. All have national accreditation through either CARF or JCAHO. The fifteen private, non-profit community mental health centers in Arkansas provide the majority of direct care services through contract with the Division of Behavioral Health Services. These centers have assumed the leadership role in organizing and developing a full array of community-based mental health services for children. Children's services offered through the public mental health system include traditional out-patient services, assessment and plan of care, crisis stabilization intervention, on-site/off-site intervention, rehabilitation day service and crisis intervention. Seven of the fifteen community mental health centers have therapeutic foster care programs for children and adolescents in state custody with serious emotional disturbance. Other services available are case management, home-based services, as well as wraparound services and school-based mental health services. Three community mental health centers provide psychiatric residential treatment services. One of these residential programs serves adolescents dually-diagnosed with substance abuse and mental health diagnoses. Specialized programs for children and adolescents are also available in some areas of the state such as alcohol treatment programs, both on an outpatient and inpatient basis, juvenile diversion programs, and supervision for juveniles discharged from the youth services center.

Available Services and Resources in A Comprehensive System of Care

Arkansas remains committed to building a mental health care system that supports the individual child and his/her needs. The child's family should have access to a network of both formal and informal supports. The following support services are available in Arkansas. Many of the listed available services and resources have a representative on the CASSP Coordinating Council. Agencies and stakeholders, both public and private meet monthly to plan and implement a coordinated system of care for children and adolescents with serious emotional disturbance and their families.

Child and Adolescent Service System Program (CASSP)

The children's mental health system in Arkansas uses the CASSP model of an integrated system of care. Act 964 of 1991 established CASSP. Act 1517 of 2001 and Act 2209 of 2005 made revisions to the law to better meet the needs of children in our mental health system. The

purpose for creating CASSP included the need for "a structure for coordinated policy development" and "comprehensive planning" in regard to children's mental health services in Arkansas. Specifically, an intention of this law is "to build on existing resources," as well as "design and implement a coordinated service system which is child and family centered and community-based." CASSP is based on values for an ideal system of care for mental health services for children and families.

CASSP Regional Plans are revised and reviewed each even-numbered year by the CASSP Teams to identify and recommend program initiatives to the CASSP Coordinating Council, based on area and community-based needs. In addition, Act 2209 of 2005 designates the Division of Behavioral Health Services (DBHS) as the state agency responsible for the coordination and oversight of a Comprehensive Children's Behavioral Health System of Care Plan. The plan is to be completed by April 2006. This legislation requires all state agencies to provide financial data regarding funds that support behavioral health services. Interagency agreements between DBHS and all other state agencies have been completed. Public and private stakeholders as well as parents and families will take part in the development and implementation of this plan. Having this comprehensive, collaborative approach to development of a plan for children's behavioral health services should decrease fragmentation and duplication within the system of care.

The state level CASSP Coordinating Council identified the following service priorities as a focus for 2005-2006:

- Early childhood, Head Start population.
- Discharge planning for children and adolescents in hospitals, residential treatment facilities, and those transitioning from other placements and returning to community, and availability and access to appropriate services upon discharge.
- Special populations-juvenile justice, therapeutic foster care, adjudicated delinquents, hearing impaired.
- Dually-diagnosed mental health/mental retardation and mental health/substance abuse.
- Work force issues- hiring and retaining both mental health professionals and paraprofessionals.
- School-based mental health services.

Arkansas Rehabilitation Services

The General Field Program provides a wide array of services designed to assist individuals with disabilities in obtaining and keeping employment. Federal, state, and local partnerships have been developed with public schools and interested individuals and agencies that serve persons with disabilities. The ARS Field Program operates 20 statewide offices for persons with physical, mental, cognitive or sensory disabilities. There are components within the rehabilitation system that provide specialized programs, such as transition services for students who are finishing school; services to help those who are presently receiving public assistance become employed, and therefore able to provide for themselves, and services for people with special communication needs.

Arkansas Department of Health

As of July 1, 2005, the Department of Health will be placed under the Department of Health and Human Services as the Division of Health Services. The Hometown Health Improvement Project under the Department of Health brings together a wide range of people and organizations in the community to identify their health problems and develop and implement ways to solve them. On the local level this initiative stresses collaboration, coalition building, community health assessment, prioritization of health issues and the development and implementation of community health strategies that are locally designed and sustained.

Arkansas Department of Education

Arkansans have continually demonstrated a strong commitment to providing public school students with education opportunities. In 2004, the Arkansas Legislature went into special session to overhaul the public school system as a result of a lawsuit filed to ensure fairness and equity across the state for all school districts. The Lake View School District No. 25 of Phillips County led to a ruling by the Arkansas Supreme Court that the State violated the state constitutional provisions guaranteeing equal protection of the laws insofar as it denied equal educational opportunity to the public school students. The Legislature met to settle school-funding issues, which led to consolidation of some small school districts, and an increase in funding for the public education system. The increase in funding for education has had a financial impact on available funding for other state agency programs. DBHS and the Department of Education/Special Education continue to collaborate on the development of school-based mental health services.

DHS Divisions and Offices Serving SED Clients In the Public Mental Health System:

Division of Child Care and Early Childhood Education

The Division of Child Care and Early Childhood Education (DCCECE) is responsible for the regulation and inspection of all child care facilities and home day care in Arkansas. It also oversees the Special Nutrition Program, the Arkansas Better Chance Program, offers staff support to the Arkansas Early Childhood Commission, and guarantees there is an educational component in childcare programs throughout Arkansas. DCCECE is providing funding for the public mental health system for training and three demonstration projects for early childhood mental health services.

Division of Children and Family Services

The Division of Children and Family Services (DCFS) protects children and helps preserve Arkansas families, through child protection services, intensive family services, juvenile services, adoption, foster care, and residential licensing. Currently, DCFS has agreements with all fifteen community mental health centers to provide mental health services for children on their caseload with specific requirements addressing accessibility and process for interagency communication.

Division of County Operations

The Division of County Operations helps those in need. It also helps people get jobs by giving them the support and training they need to become independent. To do this, DCO has staff working in every county in the state. Some of the services provided by the division include Medicaid, food stamps, Transitional Employment Assistance, and emergency services.

Division of Medical Services
The Division of Medical Services (DMS) provides care through a network of providers to approximately 15% of the state's population through the Medicaid program and the Children's Medical Services program. The division provides a range of care from physician services to institutional care.

Division of Behavioral Health Services
The Division of Behavioral Health Services (DBHS) provides an integrated system of public mental health care to Arkansas residents. Services provided by this division are forensic psychiatric services, adolescent inpatient services, adolescent sex offender services, research and training. Comprehensive, contracted services are also offered by fifteen independent community mental health centers located throughout the state.

Division of Behavioral Health Services- Substance Abuse Services
Alcohol and Drug Abuse Prevention is under the Division of Behavioral Health Services. The mission of Alcohol and Drug Abuse Prevention is to help Arkansas citizens live productive lives, free from the abuse of alcohol, tobacco, and other drugs.

Division of Developmental Disabilities Services
Developmental Disabilities Services (DDS) helps people with developmental disabilities and their families in their homes, communities, or residential programs. The primary developmental disabilities are mental retardation, cerebral palsy, epilepsy, and autism. Among those services provided are diagnosis and evaluation, early intervention, case management, family support, residential care, and habilitation and education.

Division of Youth Services
The Division of Youth Services (DYS) protects public safety while helping youthful offenders choose productive lives and stay out of trouble by providing diagnostic and evaluation services for delinquent youth committed to DYS by a juvenile judge. It also provides residential treatment for youth that do not require serious offender programs and operates the serious offender program.

<u>Other Support Services</u>

Arkansas Mental Health Planning and Advisory Council
The Arkansas Mental Health Planning Advisory Council is set up by five regions. The total membership of the Advisory Council is 61. Nine of those members are family members of children with SED. There are also members who have special interest in children's services, who serve on the CASSP Coordinating Council.

National Alliance for the Mentally Ill - Arkansas
NAMI-Arkansas is a non-profit, grassroots organization dedicated to improving the lives of those affected by mental illness, their families and their communities through advocacy, education, and support. NAMI places the highest priority on medical treatment, services,

education, and rehabilitation for persons with brain disorders, as well as research aimed toward the ultimate prevention and cure of these disorders.

- NAMI-Arkansas participates as a member of the CASSP Coordinating Council and was a supporter of specific legislation regarding mental illness during this past Arkansas Legislative session.
- NAMI-Arkansas provides education for facilitators of its support groups at no cost to the participants.
- The NAMI-Arkansas State Office provides educational materials through a 1-800 information line in which callers can request information about specific illnesses.
- NAMI-Arkansas provides an informational website.
- NAMI-Arkansas assisted UAMS as part of the committee that worked on the Nickey Neuron video project that is now part of the Discovery Museum's exhibit on the brain.
- NAMI-Arkansas is a partner in the annual AETN children's mental health broadcast each May for Mental Health Month. NAMI-Arkansas members participate as panelists during the broadcast, help man the phones during the broadcast, and mail all the information packets following the broadcast.
- NAMI-Arkansas sponsors an annual candlelight vigil held at the state capitol on the first week in October marking the beginning of Mental Illness Awareness Week. In October 3, 2004, a ten-year-old student from Jacksonville, was featured in the programs as she read her poem "Remember the Kids." This year's vigil is scheduled for October 2, 2005.

Disability Rights Center

The Disability Rights Center is the Protection and Advocacy system and Client Assistance Program for people with disabilities in Arkansas. Each state and territory has a P&A and CAP responsible for pursuing legal, administrative and other appropriate remedies under federal and state statutes to protect the rights of individuals with disabilities. Investigation of allegations of abuse and neglect of persons with disabilities residing in facilities or in the community is another function. DRC, a nonprofit agency, is independent from state or local government. DRC focuses on broad areas of emphasis and develops priorities and objective each year in these areas. In general the DRC areas of emphasis are in education, abuse and neglect and quality assurance, employment, access to services, and community integration. During this current fiscal year, DRC is maintaining a presence in facilities and community programs for people with mental illness, developmental disabilities and other disabilities to monitor, investigate and attempt to remedy adverse conditions and situations. DRC is devoting considerable resources to advocate for access to inclusive educational programs, medical coverage, competitive employment, accessible affordable housing and restaurants.

Arkansas State Hospital

In addition to funding provided for community mental health programs, the Department of Human Services operates one State Hospital that has a 16-bed unit for adolescents, ages 13-17. Admissions are comprised of adolescents from all areas of the state. Community mental health centers have been designated as the single point of entry for adolescents being considered for admission to the Adolescent Inpatient Treatment Unit (AITU) of the Arkansas State Hospital. Through single point of entry, these youth are required to be assessed at the community mental health center to determine the most appropriate and least restrictive level of care required. If admission to AITU is determined to be appropriate, discharge planning should begin at the point

of admission with the local community mental health center's children's staff to provide for a smooth transition back to the home community when the youth is discharged. If an adolescent is screened for admission to AITU and hospitalization is deemed inappropriate, the community mental health center coordinates, in cooperation with other child-serving agencies/divisions, more appropriate services for the adolescent and family.

In Arkansas, psychiatric hospitalizations for children are primarily funded through Medicaid and are provided by private hospitals. ASH has only a sixteen-bed adolescent program, that can be utilized as either acute care or longer term residential treatment. Due to the low number of adolescents hospitalized in the state-run facility, the number of readmissions to the ASH adolescent unit is not statistically significant. In addition, due to the fact that many adolescent admissions to ASH are considered "treatment failures" with a history of multiple hospitalizations in private programs, the population tends to be some of the most severely disturbed children in the state. In an effort to move these adolescents to lesser restricted services in the community, the ASH adolescent unit has developed agreements with community providers that ASH will readmit for stabilization if those clients decompensate while in the community programs. This practice may increase the number of readmissions, but follows the goal to reduce hospitalization by reducing the number of days and lengths of stay for those children. The Division of Behavioral Health Services, Arkansas State Hospital receives funding from the Department of Human Services to operate a 16 bed residential Sex Offenders Program for adolescents. The overall rates for the unit shows 35% of these adolescents graduate from the program. Another 23% are discharged, but have made some progress, and 42% are discharged for no progress. DHS also contracts with private providers to provide residential and outpatient services to this population. These programs and others located throughout the state are utilized to decrease the number of children who are sent out of State for treatment.

CASE MANAGEMENT SYSTEM

Arkansas has targeted its system of care services, including case management to children with serious emotional disturbance and their families. To maintain and/or increase these services is a primary goal for us as well as of the mental health block grant law. The CASSP population subgroup should receive case management services because of their substantial use of public resources (funding and services), the complexity of their mental health and other service needs, and the benefit of case management in assuring desirable client-driven outcomes. Persons receiving substantial amounts of public funds include children and adolescents eligible for Medicaid, as well as those children in the child welfare system that have been diagnosed as having a serious emotional disturbance by a mental health professional at a community mental health center. Statistics show that approximately 25,000 children and adolescents receive services through a community mental health center. Case management services were provided to more than 9,400 children and adolescents of the 16,588 diagnosed with serious emotional disturbance.

Since resources are not available to adequately serve the population of children falling within the SED guidelines, it is necessary to prioritize resources to subgroups of the population. DBHS and the community mental health centers will focus on serving children and adolescents within the target population who are at imminent risk of being removed from their families and those who have been referred by community mental health centers to psychiatric hospitals, psychiatric

residential treatment facilities, and therapeutic foster care programs. Currently, Therapeutic Foster Care (TFC) is the only evidenced-based practice that has been implemented in Arkansas on a statewide basis. Seven CMHCs and an affiliate program out of twelve providers are providing TFC. There were 237 children and adolescents served by the community mental health programs in SFY 2004. DBHS worked closely with the Medicaid system and the U-21 Utilization Management Company to develop a "care coordination" component of their services. This involves the expectation that all Medicaid recipients, who are hospitalized, whether in acute or residential facilities, will be referred to CASSP local service teams for the development of a multi-agency plan of services.

PERFORMANCE INDICATOR DESCRIPTION

Goal: To monitor the number of short-term readmissions to the Arkansas State Hospital.

Target: Percentage of adolescents readmitted to the Arkansas State Hospital within 30 days of discharge.

Population: Adolescents who are re-admitted to the State Hospital.

Criterion: Comprehensive, community-based mental health system.

Brief Name: 30 Day Readmission Rate

Indicator: Percentage of adolescents readmitted within 30 days of discharge from the Arkansas State Hospital.

Measure: Numerator: Number of discharges of adolescents followed by readmission within 30 days of the discharge.
Denominator: Total number of discharges of adolescents from the Arkansas State Hospital.

Sources of Information: Arkansas State Hospital Reporting System.

Special Issues: In order to be able to report 180 day readmissions, and for the 30-day and 180-day readmissions to be based on the same discharge population, the reporting time period for this indicator target will be the most recent calendar year rather than the most recent state fiscal year. Discharges will include those discharged to another facility for acute medical care. System changes are being undertaken to allow these discharges for acute medical care to be excluded in the future years. The Adolescent Unit of the Arkansas State Hospital only has sixteen beds, which will impact the validity of the readmission rates reported.

Significance: Development of more intensive aftercare services with comprehensive community-based mental health services could reduce readmissions to the Arkansas State Hospital.

PERFORMANCE INDICATOR DESCRIPTION

Goal:	To monitor the number of 180 day readmissions to the Arkansas State Hospital.
Target:	Percentage of adolescents readmitted to the Arkansas State Hospital within 180 days of discharge.
Population:	Adolescents who are readmitted to the State Hospital
Criterion:	Comprehensive, community-based mental health system
Brief Name:	180 Day Readmissions Rate
Indicator:	Percentage of adolescents readmitted within 180 days of discharge from the Arkansas State Hospital.
Measure:	Numerator: Number of discharges of adolescents followed by readmission within 180 days of the discharge. Denominator: Total number of discharges of adolescents from the Arkansas State Hospital.
Source of Information:	Arkansas State Hospital.
Special Issues:	In order to be able to report 180 day readmissions, and for the 30-day and 180-day readmissions to be based on the same discharge population, the reporting time period for this indicator target will be the most recent calendar year rather than the most recent state fiscal year. Discharges will include those discharged to another facility for acute medical care. System changes are being undertaken to allow these discharges for acute medical care to be excluded in future years. The adolescent unit of the Arkansas State Hospital only has sixteen beds, which will impact the validity of the readmission rates reported.
Significance:	The number of re-admissions to the Arkansas State Hospital could be reduced with more intensive aftercare services through comprehensive community-based mental health services.

PERFORMANCE INDICATOR DESCRIPTION

Goal: To increase active involvement in the CASSP process, of caregivers of children and adolescents with SED.

Target: 80% of caregivers of children and adolescents with SED who go through the CASSP process will have a multi- agency plan of service developed.

Population: Children and adolescents with SED who receive services through local CMHCs.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Caregivers actively involved in the CASSP process.

Indicator: Percentage of caregivers of children and adolescents with SED, and are actively involved in the multi-agency staffing and treatment planning process.

Measure: Numerator: Number of multi-agency service plans completed.
Denominator: Number of parents/caregivers of children and adolescents with SED who are actively involved in the CASSP multi-agency staffing.

Sources of Information: CMHC contract reporting system on treatment planning and the CASSP Multi-Agency Plan of Services (MAPS).

Significance: A primary goal of the CASSP Coordinating Council and Mental Health Planning Advisory Council is to have more family involvement on both the state and local levels in decisions regarding treatment, monitoring and evaluation of the public mental health system.

PERFORMANCE INDICATOR DESCRIPTION

Goal: To monitor the number of children and adolescents served by evidence-based therapeutic foster care programs within the public mental health system.

Target: The number of children and adolescents in the custody of the Arkansas Division of Children and Family Services (DCFS) who are served in evidence-based therapeutic foster care programs through community mental health centers.

Population: Children and adolescents in therapeutic foster care.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Evidence-Based Treatment: Therapeutic Foster Care.

Indicator: Percentage of DCFS children and adolescents in therapeutic foster care programs through community mental health centers.

Measure: Numerator: Number of children and adolescents in therapeutic foster care provided by community mental health centers programs.
Denominator: Number of DCFS children and adolescents in therapeutic foster care programs.

Sources of Information: DHS Annual Statistical Reporting System, Basic Services Plan Report.

Special Issues: DBHS will establish criteria for identification and reporting of the number of children and adolescents receiving evidence-based therapeutic foster care through the community mental health centers. Therapeutic foster care programs are funded through the DCFS, therefore DBHS does not have control over budget issues that might effect the number of therapeutic foster homes that are funded.

Significance: Therapeutic Foster Care is an effective treatment model and should be maintained or increased in order to meet the mental health needs of SED children and adolescents in foster care.

PERFORMANCE INDICATOR DESCRIPTION

Goal: To maintain or increase case management services for children and adolescents who receive services through the local community mental health centers.

Target: To assess the number of children and adolescents receiving case management services to use as a basis for setting future targets for expanding services.

Population: Children and adolescents diagnosed with SED at the local CMHCs.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Number receiving case management.

Indicator: Percentage of children and adolescents who receive case management services through the local community mental health centers.

Measure: Numerator: Number of children and adolescents with SED who are receiving case management services through the CMHCs during the fiscal year.
Denominator: Number of children and adolescents diagnosed with SED through the CMHCs.

Sources of Information: Contract reporting system, CMHC client information system.

Significance: Assuring that appropriate case management services are available for children and adolescents diagnosed with a serious emotional disturbance could result in decreased dependence on inpatient services for children in Arkansas.

PERFORMANCE INDICATOR DESCRIPTION

Goal: Maintain a high level of satisfaction with outcomes of service by children and adolescents/family with SED receiving services.

Target: Data on client rating of satisfaction with outcomes of care will be collected from a random sample of consumers using a statewide uniform survey metrology. Data from this survey will be used to establish a baseline performance.

Population: Sample of caregivers and children/adolescents with SED receiving public mental health services.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Client Satisfaction with Outcomes.

Indicator: Percentage of caregivers and children/adolescents sampled that express positive satisfaction with outcomes of care.

Measure: Numerator: The number of caregivers and children/adolescents surveyed who rated outcomes of care positively.
Denominator: Number surveyed who responded to survey items regarding satisfaction with outcomes.

Sources(s) of Information: Statewide, random sample, uniform consumer satisfaction survey.

Special Issues: In previous years this data was based on aggregated data from provider administered surveys, which vary in specific content among providers. For this year a statewide uniform survey will be administered to a random sample of consumers/family. Based on this methodology baseline performance will be established.

Significance: Persons satisfied with outcomes of care are more likely to follow through with receiving needed services. Achieving consumer-valued outcomes is the ultimate objective of a community-based system of care.

ii: MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY

Arkansas' total population is 2.7+ million of which 25% are children and adolescents under the age of eighteen. The 2000 census data show that 80% of the population is white; 15.7% is black or African American; less than 1% is American Indian and Alaska Native; Asian; Native Hawaiian and Other Pacific Islander, and; 3.2% is Hispanic or Latino. Over the last eleven years, Arkansas' Hispanic population has significantly increased. In 1990, the state total was 19,876 and in 2000, the total was 86,866-an increase of 66,990. U. S. Census figures indicate Arkansas' population is divided between 49% urban and 51% rural residents. There are 75 counties in the state-12 of which would be considered urban and 63 considered rural. The per capita income was reported to be $19,595 in the 2000 census.

Estimate of the incidence and prevalence in the State of serious emotional disturbance among children.

There are approximately 344,715 children and adolescents, age 9-17 in Arkansas. The estimated SED population for this group is calculated to be between 5-7% or 24,130 on the lower end and 31,024 on the upper end for children with a LOF of 50. With a LOF of 60, the estimated SED population is 11-13 percent of the number of youth 9-17 years old. The lower end is 37,919 children with the upper end of 44,813 children. The community mental health centers served approximately 25,000 children and adolescents during SFY 05, of which approximately 16,500 were diagnosed as SED.

The growth in the minority population has mostly come from the Hispanic community. In an attempt to overcome barriers which have surfaced in the formal mental health system, efforts have been focused on trying to increase hiring of minorities in the local community mental health centers when there are job openings and encouraging client use of the network of natural support systems such as extended family members, friends, churches, and self-help organizations. The goal is to provide services that are culturally sensitive and responsive to the special needs of these children and families. The mental health system should encourage, on both the state and local levels, early educational opportunities for children and eliminating any disparities in availability and access to mental health care. An ethnic minority representative serves on the CASSP Coordinating Council, and the Council has provided cultural diversity presentations to its members. The community mental health centers provide in-service training on cultural issues as a part of their staff orientation. In addition, the Annual Mental Health Institute agenda as a practice include sessions on cultural diversity issues. In rural Arkansas, the Community Mental Health Centers have increased services to the rural population and minorities through their school-based mental health programs, after school and summer programs. They have found that the demand is much greater than the financial and human resources that are available in most areas of the state.

Estimates of incidence and prevalence of severe emotional disturbance in children and adolescents in Arkansas is essential for the system of care. The new data system currently under development will be able to provide much more accurate data to utilize for system planning and improvement.

Data-Management, Reporting, and Analysis System

DBHS currently collects both client-level and aggregate-level data from the community mental health centers. The client-level data does not contain a unique identifier, so it is not possible to produce unduplicated counts of clients served. The aggregate data collected does provide information for tracking many aspects of the systems' functioning, but also does not have unique client identifiers and does not permit a breakdown of data into desired subcategories. Client satisfaction data is only available through the aggregate data collection system and the instruments used in the surveys vary among the community mental health centers. During the past year, in part with funds provided through the SAMHSA Data Infrastructure Grant (DIG), DBHS has entered into a contract with a private vendor to collect, store and report system wide client and service data. For SFY 2004, the aggregate collection of adult and child data has been completely integrated and a previous separate data collection system for children's data has been eliminated. The system being put in place operates through a secure encrypted web-based application. It includes unique client identifiers which will allow determination of unduplicated counts served, allow the linking of client data with service data, and enable the tracking of clients across the system including as they move from community-based care to treatment in the Arkansas State Hospital and vice versa. Client satisfaction surveying is also being significantly improved over the aggregated, CMHC specific system described above. With input from system stakeholders, DBHS decided to use the SAMHSA recommended MHSIP adult and child/family surveys with the addition to each of items of local interest. A random sample of 1,600 child/family clients was drawn. Surveying is currently nearing completion. Already over 400 child/family surveys have been returned.

PERFORMANCE INDICATOR DESCRIPTION

Goal: To provide an estimate based on the federal methodologies.

Target: Percentage of children and adolescents with SED who receive services through the CMHCs.

Population: Children and adolescents diagnosed with SED who can be expected to require services in the public system.

Criterion: Estimates of Prevalence and Treated Prevalence and Mental Health Systems Data.

Brief Name: Estimates of Prevalence.

Indicator: Available estimates of incidence and prevalence of severe emotional disturbance in children and adolescents in Arkansas who received publicly funded services.

Measure: Numerator: Number of children and adolescents with SED through the local CMHCs during this fiscal year.
Denominator: Estimated number of SED population who should be receiving services through the public mental health system.

Sources of Information: CMHC reporting system, DBHS data support.

Significance: Accurate prevalence and service utilization data is central to planning a system of care that meets the needs of children and adolescents, who have serious emotional disturbance. DBHS is in the third year of a SAMHSA Data Infrastructure Grant that will be very instrumental in that effort.

iii: CHILDREN'S SERVICES

CASSP

In 1991, Act 964 was enacted establishing the Child and Adolescent Service System Program (CASSP) in Arkansas. The purpose of the Act is to establish a structure for coordinated policy development, comprehensive planning, and collaborative budgeting for services to children with emotional/mental disorders and their families. It is further the intention of Act 964 to build on existing resources, and to design and implement a coordinated service system that is child and family-centered and community-based. Act 964 also established a CASSP Coordinating Council, which includes 44 representatives from State agencies and local providers of services to the target population, as well as family members, and child advocates. The Council has met quarterly since July 1991 for the purposes of providing specific guidelines for the development of regional services and plans based on the guiding principles of the CASSP system of care and for review and approval of regional plans developed by CASSP Regional Teams and incorporation of the Regional Plans into the Statewide Children's Mental Health Plan. The CASSP legislation was revised in 2001 and 2005 to better reflect what is actually happening in children's mental health services in Arkansas. The 2005 legislation requires the creation of the Comprehensive Children's Behavioral Health System of Care Plan that is developed and implemented with representatives of all state agencies receiving funding, either state or federal.

For SFY '05 and '06, the Arkansas Legislature continued state funding through the Divisions of Behavioral Health Services, Developmental Disabilities Services, and Children and Family Services for CASSP to further implement community-based services such as interagency service coordination, short term crisis intervention, single point of entry into the public mental health system and wraparound services. In its commitment to an integrated service system, the Department of Human Services' Director's Office has renewed the grant to the divisions to work collaboratively on the "Together We Can" project, which is based on CASSP principles. There are currently 36 counties with "Together We Can" programs. Funds are used for individuals and their families to preserve the family unit and enable the individual to function in his/her home environment and community. The participating agencies meet the needs of this population through individualized, coordinated, multi-disciplinary interagency processes, sharing cost and expertise. The collaborative de-emphasizes service categories in favor of creating and wrapping service categories around each family.

Early Childhood Mental Health

The Division of Childcare and Early Childhood Education (DCCECE) and the Head Start Collaboration Project are working with DBHS to promote early childhood mental health services. DCCECE is currently funding three demonstration projects and training to increase expertise in community mental health centers on a statewide basis.

Substance Abuse

The Division of Behavioral Health Services-Alcohol and Drug Abuse Prevention's policy and philosophy is that the most effective services are community-based and community-supported. They contract with local programs to establish an effective network of services. The area that helps children and adolescents most is the Prevention, Education and Early Intervention Unit. ADAP uses approximately twenty (20%) percent of the Substance Abuse Prevention and

Treatment Block Grant funds for the alcohol, tobacco and other drug abuse prevention programming. The ADAP funds thirteen regional Prevention Resource Centers to provide ATOD prevention programming services necessary to facilitate community empowerment in addressing these issues. In addition to prevention programming utilizing Substance Abuse Prevention and Treatment Block Grant funds, prevention programs are administered using the Governor's portion of Safe and Drug-Free Schools and Communities Act funds. This office provides funding, through competitive grants, to assist communities in establishing local coalitions to reinforce their drug and alcohol abuse prevention efforts. These coalitions are made up of representatives from a wide range of agencies and organizations at the local level. These coalitions provide a more coordinated effort by combining resources to more effectively provide alcohol, tobacco and other drug education/prevention/intervention programs and services. Through funding from ADAP, one of the community mental health centers operates a 24-bed residential adolescent chemical dependency treatment program. Horizon utilizes a strong multi-disciplinary approach in the treatment of chemical dependency and concomitant psychiatric problems for youth ages 13-18. ADAP also funds Dunston Adolescent Treatment Center, a 12-bed treatment program for male and female adolescents with chemical dependency. Other programs with funding through ADAP can treat adolescents 16 and above on an outpatient basis.

Juvenile Services

The Youth Services Centers serve the juveniles of Arkansas who have either come in contact with the judicial system or are in danger of coming in contact with the judicial system. To accomplish this end, The Division of Youth Services (DYS) moved toward small wilderness programs for serious offenders and community-based alternatives to incarceration. The community-based programs teach life skills and improve educational levels to help juvenile offenders before their offenses escalate. DYS is also building on a system of community providers to divert juvenile offenders to day treatment, therapeutic group homes, electronic monitoring, and independent living and restitution programs in their own communities. DYS, DBHS, and the CMHC's have worked on strengthening their relationships to better serve the mental health populations who are adjudicated through the juvenile court system. DYS also utilizes Medicaid funds to provide mental health services to their population, through a rehabilitation option waiver. Four of the 15 CMHC's contract with DYS for diversion programs for adolescents providing the following services: targeted case work management, therapy, diagnosis and evaluation, intensive case work management, intensive casework management-serious offender, interstate compact and residential treatment. In addition, the community-based providers provide emergency shelter and sanction services that included restorative justice, intensive supervision and tracking, compliance monitoring, drug screening, day services and crisis residential treatment. There were 531 commitments to youth services centers in SFY 2004. Four community mental health centers provided services to 1,891 youth in community-based (diversion) youth services programs.

Mental Health Needs of the Child Welfare Population

Due to the prevalence of mental health issues for the child welfare population, emphasis has been placed on developing services to meet the special needs of this vulnerable target group. The Arkansas Department of Human Services Division of Children and Family Services (DCFS), through grants and state general revenue, help families avoid unnecessary out-of-home

placement of their children, reunite children who have been previously placed, or provide support to permanent alternate living arrangements such as adoptions. According to the comprehensive assessment done within 90 days of entering care, ninety percent of foster children school age and above are referred for mental health services. DBHS began planning initiatives with DCFS to help meet the mental health needs of this vulnerable population. A letter of agreement between DCFS and the CMHC's address timeliness of mental health services, as well as the functions and responsibilities of each agency. In addition, DCFS has a mental health liaison that serves on the CASSP Coordinating Council and participates in CASSP site visits and other collaborative efforts on children's mental health issues.

Arkansas Department of Education-Special Education

The Special Education Unit is responsible for the oversight, administration and implementation of educational services for all eligible students with disabilities, ages 3 to 21. The unit is responsible for working with public and private agencies involved in the education and financing of educational services for this population.

The unit provides financial support to public agencies for the implementation of educational services, oversees the State's Comprehensive System of Personnel Development, provides technical assistance through consultation and professional development and manages the dispute resolution systems under the Individuals with Disabilities Education Act (IDEA) of 1997. Under this law, students are receiving an education in the least restrictive environment that includes evaluations, individualized education programs where parents and students participate in the decision making on the service plans and due process.

The unit, acting under House Resolution 5520, has developed the Arkansas Comprehensive System of Personnel Development program, which is a vital component of IDEA. ACSPD helps in assuring that all personnel serving toddlers, children and youth, birth to 21 years of age, are adequately prepared and trained.

To further address the IDEA requirements, the Division of Behavioral Health Services and the CMHCs have worked closely with the Department of Education Special Education Unit to develop and expand the School-Based Mental Health Network. The development of the School-Based Mental Health Network is supported by the ADE's willingness to promote professional accountability, without regard to student or family Medicaid or third party enrollment. Participation in the Network is based upon the guidelines summarized in the School-Based Mental Health Model. This model accentuates the importance of developing partnerships between schools, mental health agencies, and other community resources.

The number of children identified as emotionally disturbed under The Education for the Handicapped Act P.L. 94-142, is very low compared to the national average, with 718 children and adolescents ages 6-21 and 8 children ages 3-5 identified statewide through the 2004 Child Count. According to Arkansas education officials, this low identification rate can be attributed to several factors: 1) few specialized services are available for children with serious emotional disturbance; 2) significant delays are experienced in completing evaluations of children referred for P.L. 94-142, further diminishing the motivation to identify children as needing special education certification; and 3) limited federal funding subsidies to cover the increased costs for

special education services. An assessment specialist with the Department of Education/Special Education assists local school districts in serving students.

Department of Health

The Hometown Health Improvement Project brings together a wide range of people and organizations in the community to identify their health problems and develop and implement ways to solve them. This locally controlled initiative stresses collaboration, coalition building, and community health assessment, prioritization of health issues and the development and implementation of community health strategies that are locally designed and sustained. The Department provides preventive health services under the Office of Disabilities Prevention (ODP). They promote the elimination of barriers for all persons with disabilities throughout Arkansas, in partnership with other state, local, and community agencies, and persons with disabilities and their families. Public health dentists work to improve dental health through preventative measures and dental health education.

The MCH Block Grant makes funds available to the state of Arkansas: 1) to assure quality maternal and child health services to mothers and children (targeting especially the low income families; 2) to reduce infant mortality and the incidence of preventable and handicapping diseases; 3) to provide rehabilitation to children age 16 or below who are blind and disabled; 4) to locate and provide care for children with special health needs. Currently, the Division of Child Care and Early Childhood Education is implementing a maternal child health grant that focuses on social and emotional well-being of young children and utilizes a multi-agency approach for the planning and implementation for a system of care for young children. On July 1, 2005, the Department of Health will become the Division of Health Services under the Department of Health and Human Services.

Defined Geographic Area

The defined geographic area for the provision of comprehensive community mental health services for children with a serious emotional disturbance is the State of Arkansas. The system provides children's mental health services through 15 private non-profit community mental health centers. Each community mental health center is responsible for the provision of services in a geographical area defined by counties, and has a defined CASSP Regional Team within each mental health center catchment area populated. Through the CASSP Regional Team process, each "community" is allowed the flexibility to develop and expand services in ways that reflect local needs and existing resources.

PERFORMANCE INDICATOR DESCRIPTION

Goal: To maintain or increase access to school-based mental health services for children and adolescents with SED.

Target: The percentage of children and adolescents with SED that are receiving school-based services.

Population: Children and adolescents diagnosed as SED.

Criterion: Integration of Children's Services.

Brief Name: Children and adolescents receiving school-based services.

Indicator: The percentage of children and adolescents that are receiving school-based Mental health services.

Measure: Numerator: Number of children and adolescents who receive school-based mental health services through the local CMHC during the fiscal year.
Denominator: Number of children and adolescents with SED who are served through the CMHCs.

Sources of Information: Contract reporting system, CMHC client information system.

Significance: Mental health services provided in the school setting increases accessibility, especially in a primarily rural state where transportation has been identified as a major barrier of services.

PERFORMANCE INDICATOR DESCRIPTION

Goal: To monitor the number of children and adolescents who are involved with the juvenile justice system through CMHC contracts with DYS Community-based Youth Services Programs.

Target: To assess the number of children and adolescents that are receiving DYS services through contracts with the community mental health centers.

Population: Children and adolescents diagnosed with SED that are involved in the juvenile justice system.

Criterion: Integration of Children's Services.

Brief Name: Children and adolescents involved in the juvenile justice system.

Indicator: Percentage of children and adolescents that are involved in the juvenile justice system who are receiving diversion services through the community mental health centers.

Measure: Numerator: Number receiving diversion services through the community mental health centers during the fiscal year.
Denominator: Number of children and adolescents that were involved with the juvenile justice system through diversion services.

Source of Information: CMHC contract reporting system, Basic Services Plan Report.

Significance: One of the goals of the CASSP system has been to collaborate with the juvenile justice system to develop increased mental health services for this population. The juvenile justice population has a high incidence of mental illness (approximately 70 to 80 percent, according to national statistics).

iv: TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS

HOMELESS POPULATION

Using the latest census data, it is estimated that approximately 9,357 or more individuals can be described as being homeless "on any given night" in Arkansas. Of this number, approximately 3,395, or 36% are children. An estimated 1,698 homeless children are SED. The Division of Behavioral Health Services is the recipient of Projects for Assistance in Transition From Homelessness (PATH) Grant. The State of Arkansas receives $300,000 in funds each fiscal year. DBHS distributes PATH funds through a competitive basis to CMHCs who serve mental health clients. DBHS, including staff from children's services, conducted site visits with the CMHCs that received funding. Arkansas is participating in the Policy Academy on Improving Access to Mainstream Services for Homeless Families with Children. DBHS, along with eleven other state and private agencies, have been involved in the development of a strategic action plan for improving access to mainstream resources for homeless families with children and unaccompanied homeless youth. This plan was submitted in June, 2005 and outlines actions, expected outcomes, and benchmarks that are to be completed within the next two years by the policy Academy Team. DBHS will be involved in developing an inventory of available behavioral health services and service needs for this population and promoting the development of necessary services to address gaps in the service continuum in the various regions of the state Efforts are being made to better assess the gaps in services, as well as improve them, for the homeless population. The Interagency Council for the Homeless, of which the Division of Behavioral Health Services is a member, sponsors an annual conference addressing homeless issues. This year's conference, to be held in September 2005, will include a separate track related to education and all Department of Education homeless liaisons in the state will be required to attend. One full day will be devoted to presentations by HUD staff relating to funding and program issues. The Interagency Council is also working to identify the special homeless population within their own area of expertise. Once identified, individual programs are being designed to help in meeting those needs. Through the Emergency Shelter Grants Program, Emergency Community Services Homeless Grant Program, PATH, Mental Health Block Grant, Adult Education Homeless Program, Education for Homeless Children and Youth Program, Emergency Food and Shelter Program, Continuum of Care activities, Temporary Emergency Food Assistance Program, Food Stamps, Supplemental Assistance for Facilities to Assist the Homeless, and the Veteran Domiciliary Care Program, many of these special needs of the identified homeless population, such as families with children, and people with mental illness and emotional disorders are being addressed. It is our goal to increase the number of homeless children and families receiving services through PATH and other resources. In September 2004, a homeless outreach event was sponsored by the Arkansas Policy Academy as well as local, state and federal government agencies, businesses, and faith-based and non-profit organizations. Trained professionals offered medical, dental, and eye examinations and mental health screenings. Participants also received information on housing, job readiness, shelters, mental health and substance abuse services. There were 714 participants registered. The number of children and adolescents seventeen and under served was 99. As stated previously, on any given night in Arkansas there are approximately 3,395 children who are homeless, and of that number approximately 1,698 of them are SED. Grants have been awarded to school districts throughout the state under the McKinney-Vento Homeless Assistance Act. The definition of Homeless

Youth includes an individual who lacks a fixed, regular and adequate place of residence. The Department of Education has developed linkages among providers by linking homeless service liaisons in schools to the state Health Management Information System. There is also training provided in school districts to remove enrollment barriers and to improve access to community resources. School districts will also be surveyed to determine the number of children who are homeless that they are serving. All participating local educational agencies (LEAs) are authorized to provide and implement services and activities which include services to ensure that homeless children and youth enroll and succeed in school. Education and training programs are offered to parents of homeless children and youth regarding the rights their children have as homeless individuals and the educational and other resources available. While some of the obstacles faced by this population have been addressed by school districts, barriers to the enrollment, attendance and success of these children in school persist. The goal is to do a better job with identification, outreach and support.

Barriers include:

- lack of identifying homeless students within the district;
- difficulty in obtaining prior school and health records;
- school district misinterpretation of residency issues, guardian issues;
- risk of danger to children fleeing domestic violence.

RURAL POPULATION

Of the total population, 46.5% live in rural counties. Based on this, it is accurate to state that much of our services are provided to persons living in rural counties. The system currently provides services in different service sites in 69 of the 75 counties. The counties without service sites are very sparsely populated. The system will either transport children to service sites, if needed, or make services available at the child's home and/or school. In our small rural counties, a major problem affecting care is lack of adequate transportation. This includes lack of public transportation, poor roads, extremely long distances to services, and a lack of economic means to have private transportation. Many consumers live in very isolated places with no telephones. In some cases, the family's use of informal supports such as neighbors, friends and other family members, is common. The CASSP teams recognize the need for more staff at both the professional and paraprofessional level to work with children in rural areas of the state, and with minorities. However, it is often very difficult to recruit professionals to go into rural areas. While a lack of staff and financial resources is seen as a barrier, mental health providers in small communities feel they have a good working relationship with other community agencies. Reasons given for this collaboration includes the fact that they often see each other at community functions and events away from the work place. They often work together to provide what is needed for their community with limited resources. Providers and their staff usually have a good working knowledge of existing community resources. Rural counties report having a number of volunteers in their areas who participate in community projects. The local law enforcement agencies have also been known to be helpful in supporting community agencies working with children and adolescents with SED.

CASSP Regional Teams report on progress in expanding and developing services, such as school-based and summer programs in rural Arkansas for children and adolescents with serious emotional disturbance. Services are coordinated and reviews held with Together We Can teams in rural counties where this program is offered to pool resources. These teams are now available

in 36 counties. In some counties, the CASSP local service teams meet in conjunction with the TWC team. CASSP Team members have become active in providing health fairs and other community activities that involve families who would not ordinarily come in to a clinic for outpatient services. Other areas in need of development and expansion have been identified by the CASSP Regional Teams. Some needs are unique to the area, while others, such as transportation, continue to be a problem throughout the State, but is especially problematic in the more rural areas. Community -based services for dual-diagnosis (MH/SA and MH/DD) clients are still very limited. Very few options for responding to a crisis (e.g., observation beds) are available, other than referral to inpatient services.

PERFORMANCE INDICATOR DESCRIPTION

Goal: To increase identification of children and adolescents who are homeless and are receiving services through the local community mental health center.

Target: Awareness of the percentage of children and adolescents who are homeless and are receiving services through local community mental health center will increase.

Population: Children and adolescents who are diagnosed with SED and are homeless.

Criterion: Targeted Services to Homeless and Rural Population.

Brief Name: Homeless and Rural Populations.

Indicator: The percentage of children and adolescents with SED who are homeless and are receiving services through the local community mental health center.

Measure: Numerator: of children and adolescents with SED who are identified as homeless and are receiving services through the local community mental health center during the fiscal year.
Denominator: Estimated count of homeless children and adolescents with SED.

Sources of Information: PATH Grant Coordinator, CMHC- CASSP, Department of Education, DBHS Enhanced Data Reporting System.

Significance: There is a need to increase identification of the numbers of children and adolescents who are homeless and who are receiving services through the local community mental health center, and to begin collecting data on those children and adolescents who are identified through the Department of Education.

PERFORMANCE INDICATOR DESCRIPTION

Goal: To increase the number of children/adolescents with SED and their families in rural counties who are receiving services through the local CMHCs.

Target: The percentage of children and adolescents with SED and families in rural areas that are receiving services will increase.

Population: Children/adolescents diagnosed with SED and their families

Criterion: Targeted Services to Homeless and Rural Populations

Brief Name: Homeless and Rural Populations

Indicator: The percentage of rural children/adolescents and their families who are receiving services through the local CMHCs.

Measure: Numerator: Number of rural children/adolescents with SED and their families receiving services through the local CMHCs during the fiscal year.
Denominator: Number of children/adolescents with SED who are receiving services through the local CMHCs.

Sources of Information: CMHC contract reporting system, DBHS Enhanced Data Reporting System

Significance: Assuring access and availability of services of the SED rural population.

v. MANAGEMENT SYSTEMS

The presentation of a complete picture of the sources and levels of financing for children and adolescents with serious emotional and mental disorders is difficult because each of the key agencies serving the population has its own unique budgeting and expense monitoring procedures. Further, services for children with serious emotional and mental disorder are not program or cost-center specific, but are provided within programs that serve a broader population of clients. For example, outpatient services are frequently not tracked separately for children and adults. In addition, the development of an accurate financial presentation is complicated by the fact that definitions of children and adolescents with serious emotional and mental disorders differ among agencies, thus creating additional difficulties for cross-agency comparisons. Given these limitations, the following table documents the major funding sources for the target population.

FUNDING SOURCES AND AMOUNTS FOR CHILDREN AND ADOLESCENTS WITH SERIOUS EMOTIONAL DISTURBANCE

- Division of Behavioral Health Services $4,682,579
- Division of Children & Family Services $13,500,000
- Division of Developmental Disabilities $200,000
- Division of Medical Services (Medicaid) $168,540,000 (SFY2004, SFY 2005 is expected to have at least a 20% increase)

The primary source of funding for mental health services for children and adolescents is Medicaid, which is administered by the Division of Medical Services. Title XIX (Medicaid) supports a substantial level of services for the target population. The Divisions of Behavioral Health Services and Children and Family Services also receive funds for children and adolescents with emotional disorders. Funds managed by these Divisions come primarily from two sources, state general revenues and federal funds. All contracts through DHS are now performance-based, which includes the contracts with CMHCs for children's mental health services. The data available to DBHS is limited regarding total financing of mental health services in the Arkansas. First, no private insurance or self-pay resources information is available. Second, DBHS has had unreliable data from the CMHCs in the past. This information should be dramatically improved with the DBHS' enhance data system that is currently being implemented.

Staffing and Human Resource Development

Recognizing that the issues of labor force development, training and retention are critical, Arkansas has implemented several strategies that are designed to address these problems that are common to a number of states. Collaboration with other agencies and programs is an important strategy being used by Arkansas to address staffing and human resource issues. Emphasis has been put on building the system by hiring more paraprofessionals, and providing the opportunities for pre-service and in-service training to staff from multiple systems that work with the target population. There is some concern about the managed care authorization process that is in place for the U-21 Medicaid eligible population. CMHCs have had to hire additional staff to deal with the "process" which calls for the use of more administrative office staff, and not staff that are working with children. In some areas, CMHCs have lost staff that they can not afford to replace. This has led to loss of resources, which negatively affects access and availability of

services. With the use of block grant funds, changes in the system are gradually taking place to accommodate the movement to least restrictive community-based services. New roles require training of staff, development of cooperative relationships with programs that can provide that training, the use of consumers as full participants in the system and interagency collaboration with other agencies and systems that impact children and adolescents with serious emotional disorders. The following activities are being offered to promote staffing and human resource development:

Training Activities

- The CASSP Coordinating Council meets monthly at the Division of Behavioral Health Services. The Council has 44 members who are appointed by the Directors of the Departments of Human Services, Health and Education. These members represent state agencies, consumers and family members, advocacy groups, mental health providers (both public and private), and other stakeholders in children's mental health. The Council continued their CASSP Presentation Series in 2004-2005 as in-service training for the Council. Members of the Council and other invited speakers provided mini workshops on mental health issues, and how Council members' agencies interface with mental health.
- During 2004-2005, CASSP site visits were held at all community mental health centers in the State.
- Staff participates in a disabilities awareness campaign called "Can Do-Believe Achieve Campaign." This committee makes presentations and has launched a media campaign on removing the stigma of people with disabilities.
- CASSP publishes a quarterly newsletter on mental health issues of children and adolescents.
- CASSP staff has participated in four PATH site visits this FFY. These visits are helpful in knowing if children and families are benefiting from the homeless grant.
- The Division of Child Care and Early Childhood Education provided funding in the Spring of 2004 for pilot projects to support an evidence-based system of care through prevention, early intervention, and treatment services. In addition, the Division of Behavioral Health Services, Division of Child Care and Early Childhood Education, and the Head Start Collaborative provided ongoing training for community mental health center early childhood liaisons to improve mental health services for young children.
- The Statewide Conference on Juvenile Justice and Delinquency Prevention was held in September 2004. Several of the workshops dealt with mental health issues. Approximately 700 participants attended.
- The Annual Mental Health Institute is held in August of each year. Participants always share in the latest information pertaining to behavioral healthcare delivery, new treatment and service management technologies, and skills for effective diagnostic and treatment interventions. The conference provides pertinent workshops on children's issues. The Institute brings together over 1,000 mental health consumers, family members, providers, and policy makers from Arkansas and surrounding states.

Emergency Services

Provisions are made by each CMHC to arrange in-service training and training for providers of emergency health services regarding mental health. Local hospital emergency rooms have

knowledge of CMHC hotline numbers if needed. Also, the Assistant Director of Forensic Services trains approximately 125 law enforcement officers annually at the Little Rock Law Enforcement Training Academy, and he also provides training at the State Academy. Through DBHS, technical assistance and training is offered to judges, law enforcement, and prosecutors on specific cases that require emergency intervention. The Division of Behavioral Health Services has implemented the following activities:

- Developing a package of information on mental health issues for law enforcement officers that can be used for training and research.
- Providing ongoing training with officers on a quarterly basis.
- Providing training specifically for the Central Arkansas (Little Rock) police department.
- Providing five sex offender management training sessions annually to police, law enforcement, courts and mental health providers.

Medicaid Programs

Over the last several years, initiatives were put in place by Medicaid to expand access and array of services to the U21 Medicaid population. An expansion of the Rehabilitative Services for Persons with Mental Illness (RSPMI) Program under Medicaid was established, allowing Master's degreed licensed mental health practitioners to become Medicaid providers, which requires certification by DBHS prior to enrollment by Medicaid. Previously, this level of mental health practitioner could not become independent Medicaid providers. Plans for collaboration with other agencies involved with their clients, as well as the ability to manage crisis outside of office hours and referral for medication management are required in order for DBHS to give certification. The other expansion involves schools as direct providers of mental health services. DBHS developed a Memorandum of Agreement with the Department of Education to specify the roles of each agency in the oversight of this program and to assure that services were established in each community with a plan of collaboration with other mental health providers. DBHS assisted the Department of Education in development of their policies and procedures, training and implementation. They published an RFP to the community mental health centers to provide school-based services requiring school-wide implementation of positive behavioral supports. Five centers are now a part of the School-based Network. This is in addition to school-based services that are currently being provided by the CMHCs. The services that can be billed to Medicaid directly by schools are not designed to be as comprehensive as the services that can be provided by the CMHCs. Therefore, the CASSP system continues to maintain as a priority, the development of more school-based services in each of the regions.

ARKids First

ARKids First B is a comprehensive benefits package (physician, hospital, prescription drug, etc.) built around preventive care services. The eligibility is based on family income limits of 200% poverty, and either the child has been uninsured for the past 12 months or has lost health insurance through no fault of the applicant family. This is available to the under age 19 population. Eligible recipients are responsible for the cost of a portion of the care which varies from $5.00 maximum for prescription drugs to 20% of the first day's hospital per diem. Recipients must meet $10.00 co-pay for outpatient services. Each recipient chooses a Primary Care Physician through the Arkansas Medicaid ConnectCare network. The mental health benefits are limited to outpatient prevention, treatment and follow-up.

APS Healthcare

APS Healthcare is the utilization management company for mental health services for the U21 Medicaid eligible population. They provide a "care coordination" component to improve the coordination of services between inpatient and outpatient services, concentrating on those children that are the highest utilizers of services. This component of the contract was increased for SFY2006. They are also providing data regarding recipient utilization and provider practice, which will enable the state to make better policy decisions regarding the system of care. The Quality Improvement Committee (QIC) was developed to assist in the revision and improvement of the utilization management process. DBHS chairs this committee, and members include mental health center staff and multiple stakeholders from both public and private agencies.

Block Grant Funds Allocation

Block Grant funds will be allocated to the private non-profit community mental health center for the purpose of supporting the services goals and objectives delineated in criteria 1-5 of the State's plan for children/adolescents with serious emotional disturbance, as well as addressing the specifics of the CASSP regional plans developed for each geographical area. These funds will be allocated on a per capita basis (2000 census population ages 18 and below). The grant under section 1911 for the fiscal year involved will not be expended to provide any service of such system other than comprehensive community mental health services. Table 1 and Table 2 in the Adult Plan (pages 60 and 61) provides data on specific allocations and resources for both children and adult services.

PERFORMANCE INDICATOR DESCRIPTION

Goal: Regularly monitor the operation of the Medicaid U-21 utilization management system.

Target: Hold at least 80% of the scheduled Quality Improvement Committee meetings.

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Population: Children and adolescents with SED.

Criterion: Management systems.

Brief Name: QIC Meetings.

Indicator: Percentage of QIC meetings held out of those scheduled.

Measure: Numerator: The total number of QIC meetings held.
Denominator: Total number of QIC meetings scheduled.

Sources(s) of Information: Division of Behavioral Health Services.

Special Issues: None.

Significance: The Quality Improvement Committee meetings have proven to be invaluable for the Division of Behavioral Health Services and providers. This committee has been able to work closely with the Medicaid Utilization Management system. This has resulted in quickly identifying and correcting problems within the system; information sharing among providers, the DBHS, DMS and the Utilization Management contractor.

2) GOALS, TARGET AND ACTION PLANS

The Performance Indicator Tables for the goals listed for the five criteria areas below appear at the end of this section. DBHS is initiating a new, enhanced client and services data system and a statewide uniform consumer satisfaction survey. DBHS will be collecting and establishing baseline performance data rather than setting a numeric target as had been done in previous year plans. The specifics of each baseline data collections will be detailed below.

i. COMPREHENSIVE COMMUNITY-BASED MENTAL HEALTH SYSTEM

DBHS plans to maintain a basic comprehensive community-based children's mental health system of care that delivers services to children and adolescents that are viewed by the child/family as being accessible and effective. DBHS plans to move the system of care towards the delivery of care using evidenced-based practices, specifically focusing on therapeutic foster care programs. DBHS will also make a determination of the level of availability of other evidenced-based practices and develop data system capability to reliably measure the numbers of clients receiving these services.

Goal i. A. To monitor the number of short-term readmissions of adolescents to the Arkansas State Hospital.
Goal i. B. To monitor the number of 180 day readmissions of adolescents to the Arkansas State Hospital.
Goal i. C. To increase active involvement of caregivers of children and adolescents with SED who go through the CASSP process that requires a multi-agency staffing and treatment plan.
Goal i. D. To monitor the number of children and adolescents served by evidence-based therapeutic foster care programs within the public mental health system.
Goal i. E. To maintain or increase case management services for children and adolescents who receive services through the local community mental health centers.
Goal i. F. To maintain a high level of satisfaction with outcomes of service by children and adolescents/family with SED receiving services.

ii. MENTAL HEALTH SYSTEM DATA EPIDEMIOLOGY

DBHS will continue to monitor the public mental health system in terms of providing services to its target population of children and adolescents with SED. The new enhanced data system will, for the first time, have system wide unique client identifiers that will allow the determination of the unduplicated numbers of clients served. The amount of duplication in the previous counts reported is unknown and, for this reason, the goal for this plan is to establish a baseline of unduplicated number of children and adolescents with SED that were served by the community mental health system. The public mental health system will determine the unduplicated number of clients served in the state's public mental health system to establish a baseline a service penetration rate based on this unduplicated count.

Goal ii. A. To provide an estimate based on the federal methodologies.

iii. CHILDREN'S SERVICES

The system provides children's mental health services through 15 private, non-profit community mental health centers. Each community mental health center is responsible for the provision of services in geographical areas defined by counties, and under the CASSP process, each area is allowed the flexibility to develop and expand services in ways that reflect their local needs and existing resources. DBHS will maintain a comprehensive community-based system of care for children's mental health services.

The goal is to expand evidence-based school-based mental health services through grants to the community mental health centers that join the School-based Mental Health Services Network. Other community mental health centers will continue to provide services in the schools as they have for many years.

DBHS will also monitor progress of juvenile offenders who are participating in diversion programs through contracts with community mental health centers.

Goal iii. A. To maintain or increase access to school-based mental health services for children and adolescents with SED.
Goal iii. B. To monitor the number of children and adolescents who are involved with the juvenile justice system through CMHC contracts with DYS Community Youth Services Programs.

iv. TARGETED SERVICES TO RURAL AND HOMELESS POPULATIONS

The community mental health system is largely developed to serve the rural population and continues to focus on serving this population. Over half of the state is still considered to be rural as defined by residing in a county that is not part of a Metropolitan Statistical Area. DBHS plans to continue its emphasis on services to this target population.

As a primary indicator in the Block Grant, the public mental health system in Arkansas has placed priority on ensuring that children and adolescents in rural areas receive services that are accessible and available when needed. For those who find it difficult to get to the local community mental health centers, other options are for services to take place in the home or school. Some of the CMHCs have also leased or purchased vans to provide transportation, but most see the lack of transportation for families as a serious problem. Block grant funds and funding provided through community initiatives have been used to maintain, and in many instances, increase services to the rural population.

There is a need to increase services to homeless children and adolescents. DBHS participates on an Interagency Council task force that works with the Department of Education and other agencies to plan a conference and participate in other activities related to improving services to the homeless population. DBHS children's services will continue to participate in the site visits for the PATH Grant in an effort to educate staff and improved services to families with children who are eligible for services.

Children and families from rural areas will continue to be targeted for additional case management services that will take services to the child and family in settings such as the schools and home in an effort to address the full range of needs for this population. Housing status, including homelessness, is one of the fields in DBHS's new enhanced data system.

Goal iv. A .To increase the number of homeless children with SED and their families receiving services through the local community mental health centers.

Goal iv. B. To increase the number of children with SED and their families in rural counties who are receiving services through the local CMHC.

v. MANAGEMENT SYSTEMS

The Rehabilitation Services for Persons with Mental Illness (RSPMI) program has been expanded to include providers other than community mental health centers. Also, a Medicaid program to allow schools to become providers of mental health services is available. DMS requires that all providers have certification by DBHS prior to enrollment as an RSPMI provider. This collaborative approach to managing mental health services funded by Medicaid is being strengthened through current policy changes.

DBHS will continue to provide training activities for mental health professionals and paraprofessionals. As described previously in the plan, the Division of Child Care and Early Childhood Education will continue to fund training for the public mental health system to improve capacity to serve the young child.

DBHS will continue to monitor access to services for children and adolescents with SED that are Medicaid-eligible, through the utilization management, prior authorization program.

Goal v. A. To monitor access to service for children and adolescents with SED that are Medicaid-eligible, through oversight of the utilization management, prior authorization program.

Performance Indicator Table for State Plan-Children

Name of Performance Indicator: Child and Adolescent 30-Day Readmissions Rate
Population: Children and Adolescents with SED
Criterion: Comprehensive Community-Based Mental Health Service System.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator			****New Indicator**	19.3%	
Numerator				16	
Denominator				83	

Name of Performance Indicator: Child and Adolescent 180-Day Readmissions Rate
Population: Children and Adolescents with SED
Criterion: Comprehensive Community-Based Mental Health Service System.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator			****New** Indicator	34.9%	
Numerator				29	
Denominator				83	

Name of Performance Indicator: Caregivers Actively Involved in CASSP Process
Population: Children and Adolescents with SED
Criterion: Comprehensive Community-Based Mental Health Service System.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator		****New** Indicator	95%	New Measure	
Numerator			408		
Denominator			430		

Name of Performance Indicator: Number Receiving Case Management
Population: Children and Adolescents with SED
Criterion: Comprehensive Community-Based Mental Health Service System.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	72%	65%	**New Data Collection**	57%	
Numerator	6,650	6,000		9,412	
Denominator	9,189	9,189		16,588	

Name of Performance Indicator: Consumer Satisfaction with Outcomes of Service
Population: Children and Adolescents with SED
Criterion: Comprehensive Community-Based Mental Health Service System

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator		****New** Indicator	**N/A**	Establish Baseline	
Numerator		---			
Denominator		---			

Name of Performance Indicator: Evidence-Based Therapeutic Foster Care Provided by CMHCs
Population: Children and Adolescents with SED
Criterion: Comprehensive Community-Based Mental Health Service System

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator		****New** Indicator	90%	80%	
Numerator			237	210	
Denominator			264	264	

Name of Performance Indicator: Estimates of Prevalence
Population: Children and Adolescents with SED
Criterion: Mental Health System Data Epidemiology.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	100%	70%	**New Data Collection will use Federal Definition**	69%	
Numerator	9,189	9,189		16,588	
Denominator	9,189	13,000		24,130	

******The estimated SED population for this group (9-17 years old) is calculated to be between 5-7% or 24,130 on the lower end for children and adolescents with a LOF of 50.

Name of Performance Indicator: Children Receiving School-based Services
Population: Children and Adolescents with SED
Criterion: Integration of Children's Services.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	49%	46%	**New Data Collection**	39%	
Numerator	4,584	4,300		6,531	
Denominator	9,189	9,189		16,588	

Name of Performance Indicator: CMHC Children Involved With the Juvenile Justice System
Community-based Youth Services Programs
Population: Children and Adolescents with SED
Criterion: Integration of Children's Services.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	****New** Indicator	N/A	**New Data Collection**	26%	
Numerator				1,891	
Denominator				7,276	

Name of Performance Indicator: Homeless Population
Population: Children and Adolescents with SED
Criterion: Targeted Services to Rural and Homeless Population.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	12%	18**%**	41%	35%	
Numerator	200	300	693	600	
Denominator	***1,698**	**1,698**	**1,698**	**1,698**	

(*Estimated)

Name of Performance Indicator: Rural Population
Population: Children and Adolescents with SED
Criterion: Targeted Services to Rural and Homeless Population.

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Projected	FY2005 Target	FY 2006 Target	FY 2007 Target
Performance Indicator	59%	56%	**New Data Collection**	60%	
Numerator	5,480	5,200		9,944	
Denominator	9,189	9,189		16,588	

Name of Performance Indicator: QIC Oversight of Utilization Management System
Population: Children and Adolescents with SED
Criterion: Management Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	**N/A**	**New** Indicator	100%	83%	
Numerator			12	5	
Denominator			12	6	